MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06726

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Baltimore
City or town: Turnered Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Turnered Station
(If outside city or town limits, write RURAL and give nearest town)
Street No. 211 Hendricks Ct.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mania Alston

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Widow

6.(b) Name of husband or wife: Allen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 28, 1883

8. AGE: Years	Months	Days	If less than one day
64			..... hrs. ..... min.

9. Birthplace: N. Carolina (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER — 12. Name: Henry Whitley
13. Birthplace: N.C.
MOTHER — 14. Maiden name: Mary Tyler
15. Birthplace: N.C.
16. Informant: Alice Rogers
Address: 211 Hendrick Ct
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 9/47 (month) (day) (year)
Cemetery or crematory:
Location: Little Zion N.C.
18. Funeral director: Mrs Pott A. Elliott Dept
Address: 1124 N. Carolina St
19. 8-19-1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 19 47, at 1:09 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 19 47, to Aug 16 19 47 and that I last saw her alive on Aug 15 19 47

	DURATION
Immediate cause of death: Cerebral Apoplexy	
Due to: Hypertension	Undet.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H. Garland Shinall Jr. M.D.
M. D. or other
Address: 423 New Pittsburg Ave. Date signed: 8-16-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

CERTIFICATE OF DEATH

067271

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Balto.

City or town Halethrope (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Balto.

City or town Halethrope (If outside city or town limits, write RURAL and give nearest town)

Street No. 4609 Ridge Ave. (If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME IDA STEVENS ANSTINE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Daniel Webster Austine

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1879

8. AGE: Years	Months	Days	If less than one day
67	8	5	..... hrs. ..... min.

9. Birthplace Washington D. C. (Town, county, and state)

10. Usual occupation Home

11. Industry or business

FATHER 12. Name Thomas M. Baldwin

13. Birthplace Wash. D. C.

MOTHER 14. Maiden name Margaret Heisey

15. Birthplace Unknown

16. Informant Mr. J. Morgan E. Wright Son

Address 4511 Ridge Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/6/47 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Baltimore Md.

18. Funeral director WM. J. TICKNER & SONS INC.

Address North & Pa. Aves. Balto. 17, Md.

19. 8.6 19 47 C. A. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3, 1947 19 ..... at 2:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 3, 1947, to Aug 3 1947

and that I last saw her alive on Aug 3 1947

Immediate cause of death	DURATION
(a) Respiratory Failure	36 hrs
Due to (b) Pulmonary Congestion	36 hrs
Due to (c) Hypostatic Pneumonia	36 hrs
Other conditions Fracture of Left Femur	Autumn

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/5/47

Where did injury occur? Halethorpe Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fall in kitchen Injured at work? (9/9/47 CA)

23. SIGNATURE Lauren B. Thomas M. D. or other

Address 4201 Fredrick Ave. Date signed 8 Aug 47

Evidence for the change of year of birth is shown on G 111 8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

06728

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville 28
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Three (3) days
Hospital, Institution, or street address where death occurred: Hood Nursing Home
How long in hospital or institution? Three 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville 28
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARGARET BALDERSON

3.(b) Social Security Number

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife: James J. Balderson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 4 1878

8. AGE: Years: 69 Months: Days: If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: William Murray
13. Birthplace: Maryland

MOTHER
14. Maiden name
15. Birthplace

16. Informant: William E. Balderson
Address: 3702 W. Franklin St. Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 8, 1947 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Balto. Md.

18. Funeral director: Edward J. MacNabb
Address: Catonsville 28 Md

19. 8-8 1947 Harry W. Miller Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 August 1947, at 6.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 to 2 Aug 1947 and that I last saw h. E.R. alive on 2 Aug 1947

	DURATION
Immediate cause of death: Hypostatic pneumonea	2 days
Due to: Arteriosclerotic Cardio Vascular disease	2-4 yrs
Due to:	
Other conditions: Decubitus ulcers, fractured left femur	2 months 2 months

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 6/24/47
Where did injury occur? Catonsville, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Home (6/24/47 15)
Means of injury: Fall Injured at work?

23. SIGNATURE: Stephen Lee Magness M.D.
M. D. or other
Address: 752 Frederick Ave Date signed: 6 Aug '47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1860

06729

CERTIFICATE OF DEATH

BC

Reg. Dist. No. 38

1. PLACE OF DEATH:
County PRES. HOME Balto.
City or town TOWSON MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution? 17 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County BALTO City
City or town BALTO
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1311 JOHN ST.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME ANNA LOUISE BANGS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	W	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 19 59

8. AGE: Years	Months	Days	If less than one day
87	7	13	hrs. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

FATHER
12. Name CHARLES BANGS
13. Birthplace WASHINGTON D.C.

MOTHER
14. Maiden name REBECCA McCANN
15. Birthplace WASHINGTON D.C.

16. Informant J. P. ELLIOTT SUPT.
Address PRES. HOME - TOWSON

17. BURIAL Date thereof Aug. 6-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory OAKHILL
Location WASHINGTON D.C.

18. Funeral director John O. Mitchell & Son
Address 1900 Eutaw Pl.

19. Aug 4 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1947, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1947, to Aug 4 1947 and that I last saw h[illegible] alive on Aug 4, 1947

Immediate cause of death	DURATION
Pneumonia, lower lobe type undetermined	6 mo+
Due to Cachexia	1 mo+
Due to Senile arteriosclerosis	1 yr+
Other conditions Fracture right femur	7/5/47

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 7/5/47
Where did injury occur? Towson Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Fell getting out of bed Injured at work?

23. SIGNATURE Rollin B. Hudson M.D.
M. D. or other
Address 606 BALTO. AVE. Date signed 8/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

06730 P

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

I. PLACE OF DEATH:

County Baltimore

City or town Edgemere

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Edgemere Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2717 Sparrows Pt Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sarah Jane Bankhead

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	Widow

6.(b) Name of husband or wife Travers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1874

8. AGE: Years	Months	Days	If less than one day
73			..... hrs. ..... min.

9. Birthplace Chester S. Carolina (Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Mollie ?

15. Birthplace S.C.

16. Informant Antonio Bankhead

Address 2717 Sparrows Pt Rd.

17. Burial, cremation, or removal. Which? Burial Date thereof Aug 18/47 (month) (day) (year)

Cemetery or crematory

Location Blackstock S. Carolina

18. Funeral director Mrs Robt. A Elliott Dye

Address 1127 N. Caroline St.

19. Aug 18 1947 (Date rec'd by registrar) A.W. Tedrick Registrar

JS

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15th 1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10th 1947 to August 15th 1947 and that I last saw him alive on August 15th 1947

Immediate cause of death	DURATION
Cerebral apoplexy	5 days
Due to Hypertension and Arteriosclerosis	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P.H. Thomas M.D. M. D. or Other

Address Dundalk Md. Date signed 8/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06731

Reg. Dist. No. 9 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since April 4, 1946

Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since April 4, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Lutherville (If outside city or town limits, write RURAL and give nearest town)

Street No.: Clark & Belvoir ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Susan Barry

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel P. Barry

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 2, 1868

8. AGE: Years: 79 Months: 3 Days: 15 If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housekeeping

11. Industry or business:

MOTHER

12. Name: James Chilt

13. Birthplace: Virginia

FATHER

14. Maiden name: Lucy Whitescarver

15. Birthplace: Virginia

16. Informant: Personal History - Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/20/47 (month) (day) (year)

Cemetery or crematory: Orlean Cemetery

Location: Orlean, Va.

18. Funeral director: H. H. Weers and Son

Address: 805 E. Calvert St.

19. Aug 19 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1947, at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1946 to Aug 17 1947 and that I last saw h.. alive on August 16 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Since Nov 1942

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op.: .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. A. Bridges M. D. or other

Address: Towson 4, Maryland Date signed: Aug 17/47

06732

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52a BC

CERTIFICATE OF DEATH

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: .....
Wife's Address: No address on veteran.
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3228 Kingsley Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: CHARLES L. BARTON

3.(b) Social Security Number: 214-22-7110

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married - Separated

6.(b) Name of husband or wife: Marie E. Barton
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): 8-10-87

8. AGE: Years	Months	Days	If less than one day
59	11	21	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: Charles Barton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Thompson
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/5/47 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland
18. Funeral director: Howard Henry M. Blight, Jr. Blight Funeral Home
Address: 4914 Belair Rd., Baltimore, Md.

19. 8-4 1947 (Date rec'd by registrar) A. W. Haligh (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1 19 47 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 47 to August 1 19 47 and that I last saw him alive on August 1 19 47

Immediate cause of death	DURATION
Metastatic Carcinoma, left lung	2 Wks.
Due to: Hypernephroma	10 Months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Allison
R. M. ALLISON, M. D. CLIN. DIR. M.D. or other
Address: V.A., FT. HOWARD, MD. Date signed: 8-2-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06733

922

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, Institution, or street address where death occurred:
515 Allegheny Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 515 Allegheny Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: IDA WARFEL BAYNE

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William H. Bayne
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Agust 27, 1886

8. AGE: Years	Months	Days	If less than one day
61	11	14	..... hrs. ..... min.

9. Birthplace: Talbot County, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Dunlop Warfel
13. Birthplace: Penna.

MOTHER
14. Maiden name: Fannie Miller
15. Birthplace: Penna.

16. Informant: William H. Bayne
Address: 515 Allegheny Ave., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 12, 1947 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cemetery
Location: Towson, Maryland

18. Funeral director: John Burns Sons
Address: Towson, Maryland

19. Aug 12, 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10, 1947, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7th 1947 to Aug 10th 1947 and that I last saw him alive on Aug. 9th 1947

Immediate cause of death	DURATION
Myocardial Insufficiency	
Due to Chronic Endocarditis	
Due to Pulmonary Edema	
Due to Pleural Effusion	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Dewed of J. Thos. Jenifer M. D. or other
Address: Towson 4, Md. Date signed: 8/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66734

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.,3 mos.,27 days

Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 1 yr.,3 mos.,27 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Denton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Smith Beck

3.(b) Social Security Number: 218-09-5392

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Stella Beck

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): September 12, 1905

8. AGE: Years	Months	Days	If less than one day
41	10	21	..... hrs. ..... min.

9. Birthplace: Denton, Maryland (Town, County, and State)

10. Usual occupation: Clerk

11. Industry or business:

FATHER — 12. Name: William H. Beck

13. Birthplace: Denton, Maryland

MOTHER — 14. Maiden name: Mary L. Long

15. Birthplace: Denton, Maryland

16. Informant: John Smith Beck

Address: Denton, Caroline Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 5, 1947 (month) (day) (year)

Cemetery or crematory: Denton Cemetery

Location: Denton, Maryland

18. Funeral director: L. Virgil Moore & Son

Address: Denton, Maryland

19. 8/2/47 (Date rec'd by registrar) 19..... Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2, 1947, at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6, 1946, to August 2, 1947 and that I last saw h... im alive on August 2, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs. 10 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Stewart S Shaffer M.D. (M.D. or other)

Address: Mount Wilson, Md. Date signed: 8/2/47

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66735

932 S

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills, Md (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs. 6 mos.
Hospital, Institution, or street address where death occurred: Owings Mills, Md.
How long in hospital or institution? 22 yrs. 6 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Georgia County:
City or town: Savannah
(If outside city or town limits, write RURAL and give nearest town)
Street No. 216 E. Huntingdon St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles S. Bell Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 24, 1898

8. AGE: Years	Months	Days	If less than one day
49	1	18	hrs. min.

9. Birthplace: Savannah, Ga.
(Town, county, and state)
10. Usual occupation: Inmate Rosewood -
11. Industry or business:

FATHER
12. Name: Charles S. Bell
13. Birthplace: Ancilla, Florida

MOTHER
14. Maiden name: Kate Mayey
15. Birthplace: Beaufort, S.C.

16. Informant: Institutional Records
Address: Owings Mills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 14-47 (month) (day) (year)
Cemetery or crematory: Bonaventure Cemetery
Location: Savannah Ga.
18. Funeral director: J.F. Eleine Sons
Address: Reisterstown Md.

19. Aug-15-1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 Aug 1947 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 Aug. 1947, to 12 Aug 1947 and that I last saw him alive on 12 Aug. 1947

Immediate cause of death	DURATION
Due to: Myocardial Insufficiency with complicating pulmonary	8 mos -
Due to: Edema	2 days.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

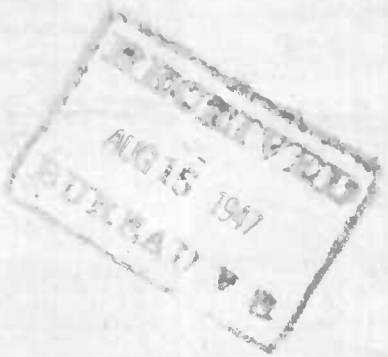
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry S. Butler, M.D. M. D. or other
Address: Owings Mills, Md. Date signed 8/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M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06736

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131b psc

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland
How long in hospital or Institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. c/o Salvation Army, S. Fremont & Hamburg St., Balto., 30, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: ABRAHAM J. BINDER

3.(b) Social Security Number: 266-10-5592

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-11-99

8. AGE:

Years	Months	Days	If less than one day
48	5	10	hrs. min.

9. Birthplace: New York City, N. Y. (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business

FATHER
12. Name: Reuben Binder
13. Birthplace: Unknown

MOTHER
14. Maiden name: Rose Blackwell
15. Birthplace: Russia

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8/23/47 (month) (day) (year)
Cemetery or crematory: Joseph Bohrer Funeral Home
Location: 94 Williston St. Bridgeport Conn

18. Funeral director: Howard N. Blight Jr.
Address: 4914 Belair Road, Balto., Md.

19. 8/23 19 47 (Date received by registrar) H. W. Hedrick Registrar DHJ.

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21 19 47 at 6:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11 19 47 to August 21 19 47 and that I last saw him alive on August 21 19 47

Immediate cause of death	DURATION
Uremia	Unknown
Due to: Chronic Glomerular Nephritis	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. M. Prep other
Address: V.A.H. FORT HOWARD, MD. Date signed: 8-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06740

CERTIFICATE OF DEATH

Reg. Diat. No. 41

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 98 Kentway

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ellen Wood Brook

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: James Brook

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 3, 1866

8. AGE:

Years	Months	Days	If less than one day
80	8	23	..... hrs. ..... min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Henry Wood

13. Birthplace: England

MOTHER

14. Maiden name: Martha

15. Birthplace: England

16. Informant: Mrs Harry Mitchell

Address: 98 Kentway, Dundalk

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 29 1947 (month) (day) (year)

Cemetery or crematory: Church of the Redeemer

Location: Bryn Mawr, Pa.

18. Funeral director: Roland L. Fisher

Address: 211 Dundalk Ave.

19. 8/28/47 19.. Mbarmine Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 26th 1947 at 4 30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 24 1947 to Aug 26 1947

and that I last saw h.. alive on Aug. 26th 1947

Immediate cause of death	DURATION
Cardiac accident	30 min.
Due to: A-S-C-V Disease	
Due to:	
Other conditions: Myocarditis —	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M Davis MD M. D. or Other

Address: Dundalk Md Date signed: 8/28/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06737

108

pc

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Spring Grove Hospital

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs. 1 mo.

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 8 yrs. 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2418 Foster Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: no ✓

3.(a) FULL NAME

Theresa Blankey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Divorced

6.(b) Name of husband or wife: unknown- Europe?

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years	Months	Days	If less than one day
80	2	12	— hrs. ..... min.

9. Birthplace: Rohatin, Austria (Town, county, and state)

10. Usual occupation: Midwife

11. Industry or business: —

FATHER

12. Name: Andrew Blankey

13. Birthplace: Austria

MOTHER

14. Maiden name: Mary Antonneavitch

15. Birthplace: Austria

16. Informant: Albert F. Blankey (son)

Address: 24 N. Linwood Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-5-47 (month) (day) (year)

Cemetery or crematory: Mt. Carmel

Location: Baltimore - Md.

18. Funeral director: Leonard J. Buck

Address: 5305 Harford Road

19. 8-4 (Date rec'd by registrar) 19 47 A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 1947, at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1947, to Aug 2 1947

and that I last saw her alive on August 2 1947

Immediate cause of death	DURATION
Lobar Pneumonia, right	18 hrs.
Due to	
Due to	
Other conditions: Chronic Myocardial Disease	years
Generalized Arteriosclerosis	years

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Leonard Buck

Title or other: Spring Grove State Hospital Aug 3, 47

Address: Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66738

131a

Reg. Diat. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Spring Grove Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 9 mo.

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 5 yrs. 9 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1130 Battery Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: --

3. (a) FULL NAME

Catherine E. Brant

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30, 1880

8. AGE: Years	Months	Days	If less than one day
67	2	3	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: --

FATHER
12. Name: John Henry Brant (deceased)
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Elizabeth Bennett (deceased)
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Bertha Robison (niece)
Address: 440 E Clement St. Balt. Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Aug 5-1947 (month) (day) (year)
Cemetery or ~~crematory~~: Loudon Park.
Location: Baltimore, Md.

18. Funeral director: G. Howard Strong
Address: 3207 W. North Ave.

19. 8-4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 1947 at 11:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31 1941 to August 2 1947 and that I last saw her alive on August 2 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	14 hrs
Due to: Hypertensive CVR disease	years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op. .....

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Duncan Turner M. D.

Spring Grove State Hospital Aug 3, '47

Address ..... Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 98

CERTIFICATE OF DEATH

66739

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 10 months, 10 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 years, 10 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: La Plata, Spring Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Bressels

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1865?

8. AGE: Years	Months	Days	If less than one day
82	?	?	..... hrs. ..... min.

9. Birthplace: United States
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-29-47 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 8/30 (Date rec'd by registrar) 19 47 J. Carroll Zimmerman per T Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 19 47, at 3:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 19 44 to August 16 19 47 and that I last saw him alive on August 16 19 47

Immediate cause of death	DURATION
Broncho pneumonia	36 hrs.
Due to: Amputation of the left fourth toe for gangrene	8 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed: 8-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information (if unknown, state correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

50

06741

38

Reg. Dist. No.

1. PLACE OF DEATH:
County Baltimore,
City or town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore,
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 325 Murdock Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charlotte Madison Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1887

8. AGE: Years 60 | Months 5 | Days 15 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Home duties

11. Industry or business

MOTHER FATHER
12. Name Rev. Joel Brown
13. Birthplace Centerville, Md.

MOTHER
14. Maiden name J. Anna Adams
15. Birthplace Darlington, Md.

16. Informant Miss. Anna Lee Brown
Address 325 Murdock Road

17. Burial Date thereof Sept 2 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Green Mount
Location Baltimore, Md.

18. Funeral director John O. Mitchell & Sons
Address 1900 Eutaw Place

19. Sept 2 1947 A. W. Wedrich Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1946, to August 30 1947
and that I last saw h.e.r. alive on August 30 1947

	DURATION
Immediate cause of death: Carcinoma of breast	2 yrs.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of breast
Date of op. April 1946.
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. S. Chaffee M.D.
M. D. or other
Address 6210 York Road Date signed

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06742

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 711 F Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MORRIS I. BRUSHWILLER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Beulah M. Brushwiller

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Feb. 19, 1884

8. AGE: Years	Months	Days	If less than one day
63	5	18	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Machinist,

11. Industry or business: Sparrows Point.

FATHER 12. Name: Theodore Brushwiller

FATHER 13. Birthplace: Baltimore

MOTHER 14. Maiden name: Margaret Braden

MOTHER 15. Birthplace: Baltimore

16. Informant: Mrs. Beulah M. Brushwiller

Address: 711 F. St., Sparrows Point-19, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 11, 1947 (month) (day) (year)

Cemetery or crematory: Lorraine Park

Location: Woodlawn, Md.

18. Funeral director: Ullrich Funeral Home

Address: 2008 Orleans St.,

19. Aug. 16 1947 (Date rec'd by registrar) Dawson L. Farber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7 19 47, at ....M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 7 19 47, to Aug 7 19 47 and that I last saw him alive on Aug 7 19 47

	DURATION
Immediate cause of death: Coronary Occlusion	Sudden
Due to: Arterio-selerotic cardio-vascular disease	10 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of 1947

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Farber, M.D.
M. D. or other

Address: Sparrows Point, Md. Date signed: 8-8-47

M

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06743

94a

Reg. Dist. No. 35

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkton Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 - 4 m

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Parkton R T D

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ANNIE LOUISA BULL

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 5 1871

8. AGE: Years	Months	Days	If less than one day
75	5	26	..... hrs. ..... min.

9. Birthplace: Parkton Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Joshua Bull

FATHER — 13. Birthplace: Parkton Md

MOTHER — 14. Maiden name: Eliza Shank

MOTHER — 15. Birthplace: York Pa

16. Informant: Mrs Linda Underwood

Address: Parkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 3 1947 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: White Hall R T D Md

18. Funeral director: Hurd & Matthews

Address: White Hall Md

19. Aug 2, 1947 (Date received by registrar) Mrs Howard S. Matthews Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 1 1947, at 3 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1947, to Aug 1 1947

and that I last saw her alive on Aug 1 1947

Immediate cause of death	DURATION
Cardiac Thrombosis	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Milner Bortner M D. M. D. or other

Address: White Hall Md Date signed: Aug 2 1947

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

C6744

CERTIFICATE OF DEATH

Reg. Diat. No. 33

1. PLACE OF DEATH:

County Balto.

City or town Reisterstown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Balto.

City or town Reisterstown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary P. Cain

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Charles Cain

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 10, 1866

8. AGE: Years	Months	Days	If less than one day
81	2	6	....hrs. ....min.

9. Birthplace Delaware (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Peckworth

13. Birthplace Unknown

MOTHER 14. Maiden name Sarah Hutchins

15. Birthplace Unknown

16. Informant Albert Peckworth

Address Woodlawn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 18, 1947 (month) (day) (year)

Cemetery or crematory Riverview Cemetery

Location Wilmington Del.

18. Funeral director J. F. Eline & Sons

Address Reisterstown, Md.

19. Aug-16-1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 August 1947, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1937, to 16 Aug 1947

and that I last saw h.. alive on 15 Aug 1947

Immediate cause of death	DURATION
Hypertensive Heart Disease	10 yrs +
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. F. Eline M.D. M. D. or other

Address Reisterstown, Md. Date signed 16 Aug 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

06745

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore, County.
City or town: Parkton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Parkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Arthur Sidney Calhoun.

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married.
6.(b) Name of husband or wife: Charmie S. Calhoun.
6.(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): January 30, 1879.
8. AGE: Years 68 Months 6 Days 21 If less than one day hrs. min.
9. Birthplace: Atkins, Virginia. (Town, county, and state)
10. Usual occupation: Farmer.
11. Industry or business: Real Estate.

FATHER
12. Name: George W. Calhoun
13. Birthplace: Virginia.

MOTHER
14. Maiden name: Alice Nash.
15. Birthplace: Virginia.

16. Informant: Mrs. Arthur Calhoun
Address: Parkton Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: August 25 1947 (month) (day) (year)
Cemetery or crematory: Greenmount Cemetery.
Location: Baltimore Md.

18. Funeral director: Jacob Hartenstein
Address: New Freedom, Pa

19. Aug 28 1947 (Date rec'd by registrar) Chester L. Fuelton Registrar
Deputy Issue

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21, 1947 at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Aug 21 1947 and that I last saw h[illegible] alive on Aug 19 1947

	DURATION
Immediate cause of death: Carcinoma of Prostate with Generalized Metastasis	2 yrs
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Milton Boston Jr M.D.
M. D. or other
Address: White Hall Date signed: Aug 23 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06746

183

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Balto
City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Sulphur Spring Rd
How long in hospital or institution? Stapleton Lake

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 Innes ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles A. Carter Jr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	

6.(b) Name of husband or wife
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 14 1933

8. AGE:

Years	Months	Days	If less than one day
14	5	10	hrs. min.

9. Birthplace: Catonsville Md
(Town, county, and state)
10. Usual occupation: School
11. Industry or business

FATHER
12. Name: Charles A Carter Sr
13. Birthplace: Howard Co Md

MOTHER
14. Maiden name: Louise Jackson
15. Birthplace: Balto Co Md

16. Informant: Charles A Carter Sr
Address: 24 Innes ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 27 47
(month) (day) (year)
Cemetery or crematory: Western Star
Location: Catonsville
18. Funeral director: Mrs Lew H Holland
Address: 1631 Druid Hill ave
19. Aug 24 1947 (Date rec'd by registrar) Geo Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1947 at 3-30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Drowning while	
Due to swimming	
Due to	
Other conditions accident	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of Aug 24 47
Where did injury occur? Relay (City or town) Balto Co (County) Md (State)
Injured at home, farm, industry, public place (where?) Public place
Means of injury Drowning Injured at work? No

23. SIGNATURE: Geo Kieffer Deputy Medical Examiner
M. D. or other
Address: 1010 Leadenhall Date signed Aug 24 47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06747

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparks (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sparks - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Belfast Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Elizabeth Ann Chilcoat

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Louis E. Chilcoat

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 5, 1864

8. AGE: Years	Months	Days	If less than one day
83	1	1	— hrs. — min.

9. Birthplace: Balto. Co. Md.

(Town, county, and state)

10. Usual occupation: Homemaker

11. Industry or business: —

FATHER

12. Name: Evan D. Wheeler

13. Birthplace: Balto. Co., Md.

MOTHER

14. Maiden name: Martha Cole

15. Birthplace: Balto. Co., Md.

16. Informant: Mrs. Geo. C. Ensor

Address: Parkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 8 1947 (month) (day) (year)

Cemetery or crematory: Bosley's

Location: Sparks, Maryland

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. 8-8- 19 47 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 6 1947 at 4 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1946 to Aug. 6 1947

and that I last saw h— alive on Aug. 5 1947

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. M. Frame M. D. or other

Address: Parkton, Md. Date signed: 8/6/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
AUG 12 1947
BUREAU F. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

66748

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore County
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days.
Hospital, Institution, or street address where death occurred:
Hood Convalescent Home
How long in hospital or Institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: 4418 Liberty Heights Ave. Balto Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Elizabeth Clark

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George W. Clark
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): November 3, 1863

8. AGE: Years	Months	Days	If less than one day
83	7	27	... hrs. ... min.

9. Birthplace: Crumpton Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John Wesley Stutes
13. Birthplace: Delaware (Crumpton Md)

MOTHER
14. Maiden name: Emily Bratton
15. Birthplace: Fort Penn Delaware

16. Informant: George S. Clark
Address: 4411 Liberty Heights Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-3-47 (month) (day) (year)
Cemetery or crematory: Crumpton
Location: Crumpton Md
18. Funeral director: Edgar L. Lane
Address: Church Hill Md
19. 9/1 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-31 19 47 at 6 40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-27 19 47, to 8-31 19 47
and that I last saw h... alive on 8-31-47 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos J Abbott M. D. or other
Address: 4509 Liberty Heights Ave Date signed: 9-1-47

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

06749 C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

96

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5029 Dunmore Avenue, Baltimore, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: COHEN, Louis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Betty Cohen

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): June 9, 1894

8. AGE: Years	Months	Days	If less than one day
52	8	1	.....hrs. .....min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: Plasterer

11. Industry or business

FATHER — 12. Name: Abraham Cohen
13. Birthplace: Russia

MOTHER — 14. Maiden name: Cacilia Malomit
15. Birthplace: Russia

16. Informant: Clinical Records
Address: Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 10, 1947 (month) (day) (year)

Cemetery or crematory: Mickro Kodesh Cong Cemetery

Location: Bowleys Lane Herring Run

18. Funeral director: Sol Levinson & Bros.

Address: 1126 W. North Ave. Baltimore, Md.

19. 8/9 (Date rec'd by registrar) 1947 J. W. Fedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 5 1947, to August 8 1947 and that I last saw him alive on August 8 1947

Immediate cause of death: DISSECTING ANEURYSM OF AORTIA; — Duration: 1 Week

PERICORDIAL TAMPONADE.

Due to: UNKNOWN

Due to:

Other conditions: NONE

(Include pregnancy within 3 months of death)

Major findings of operation: .....Date of op. .....

Autopsy results: SUBSTANTIATED ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M. D., CLINICAL DIRECTOR

Address: Vets. Adm., Ft. Howard, Md. Date signed: 8-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. 66 D67250

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Victoria Road, Victory Villa,
(c) Hospital or institution: Middle River, Balto. County, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Since July 1946

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. Victoria Road, Victory Villa, Middle River
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) NO
If yes, name country

3 (a) FULL NAME KENNETH E. COLBERT

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
World War #2	210-09-0244	Male	White	Married

6 (b) Name of ~~husband~~ or wife Ruby
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) Oct-29-1916

8. AGE: Years	Months	Days	If less than one day
30	9	11	hr. min.

9. Birthplace Derry, Pa.
(Town, county, and state)
10. Usual Occupation Finance Helper
11. Industry or business Steel
FATHER 12. Name Richard Colbert
13. Birthplace Penn
MOTHER 14. Maiden Name Myrtle Lute
15. Birthplace Hoff, Penn.
16 (a) Informant Edward Colbert
(b) Address 338-E-Lorraine Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Ave
18 (a) Funeral director Earl B. Mitchell Inc
(b) Address 403-E. 25th St.
19 (a) Aug 12-47 (Date rec'd by registrar) C. W. Gledhill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1947, at 10:30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to bullet wound of right thig with severed right femoral artery

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9:30 P.M. at August 10, 1947 M.
(b) Where did injury occur? Victoria Road, Victory Villa, Middle River
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Carl L. Royer M.D.
Medical Examiner.
Date signed 8/11/47

VS 151

VS A15 9-45-15M

06751

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 0 mos., 15 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 0 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Severna Park (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. Charles H. Corbin

3.(b) Social Security Number: #Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Elizabeth Corbin (Divorced)

8.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): October 18, 1901

8. AGE:

Years	Months	Days	If less than one day
55	9	28	..... hrs. ..... min.

9. Birthplace: Culpepper Co., Virginia (Town, county, and state)

10. Usual occupation: Miller

11. Industry or business:

FATHER — 12. Name: Earl Corbin; 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Georgia Skirtfelt; 15. Birthplace: Virginia

16. Informant: Jessie Corbin, Son

Address: Severna Park, Anne Arundel Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 18, 1947 (month) (day) (year)

Cemetery or crematory: Glen Haven Cemetery

Location: Anne Arundel Co.-GlenBurnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Maryland

19. Aug. 15, 1947 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15th, 1947 8:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31, 1947, to Aug. 15, 1947 and that I last saw him alive on August 15, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 8 yrs.

Due to: Tubercle Bacilli

Due to:

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operation: No operation — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. (M. D. or other)

Address: Mt. Wilson, Md. Date signed: 8/15/47

Rec'd - 9-18-47 - Dr. E. E. Nichols

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66752

932

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Painter Mill Road
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Owings Mills Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Painter Mill Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Jennie Cromwell Cross

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Valentine W. Cross

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): January 1, 1864

8. AGE: Years	Months	Days	If less than one day
83	7	30	— hrs. — min.

9. Birthplace: Sparks, Balto. Co., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home
FATHER 12. Name: James Howard
FATHER 13. Birthplace: Md.
MOTHER 14. Maiden name: ? Calhoun
MOTHER 15. Birthplace: Md.
16. Informant: Mrs. Grey Debaugh
Address: 703 North Bend Rd., Towson, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 3, 1947 (month) (day) (year)
Cemetery or crematory: Poplar Grove Cemetery
Location: Warren, Balto. Co., Md.
18. Funeral director: John Burns' Sons
Address: Towson, Md.
19. Sept 2 1947 (Date rec'd by registrar) A. W. Hedrick (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/1/38 19 to 8/31/47 19 and that I last saw her alive on 8/30/47 19

Immediate cause of death	DURATION
Myocardial degeneration	2yr.
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Operations:
Autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: James G. Saffell M. D. or other
Address: Reisterstown Md. Date signed: 9/1/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

66753

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:
County: Balto.
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
606 Eastern ave.
How long in hospital or institution? 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... County .....
City or town: Same
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME: Daniel Davis Jr John.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Annie Engelbright
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 8, 1866

8. AGE: Years	Months	Days	If less than one day
81	3	1	..... hrs. ..... min.

9. Birthplace: Baltimore Co. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: John
13. Birthplace: Baltimore Co.

MOTHER
14. Maiden name: Gustine Roberts
15. Birthplace: Baltimore Co.

16. Informant: Mrs. Louis E. Broom
Address: 606 Eastern Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 12/47 (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location: O'Donnell St.

18. Funeral director: Clarence F. Hoffmann
Address: 1639 Broadway.

19. 8/11 19 47 D. C. Heflich Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 9 1947, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION
Coronary Occlusion ..... Immediate
Due to ....
Due to ....
Other conditions ....
(Include pregnancy within 3 months of death)

Major findings of operations .....
..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. M. Carmine M.D.
Deputy Medical Examiner
Address: Baltimore Md. Date signed: 8/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122a

06754

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years, 2 months, 3 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 6 years, 2 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 306 North Exeter Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Toby Dellapenta

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	separated

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 8, 1881

8. AGE: Years	Months	Days	If less than one day
65	8	11	hrs. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Peddler

11. Industry or business: Miscellaneous

FATHER
12. Name: Dan Dellapenta
13. Birthplace: Italy

MOTHER
14. Maiden name: Mary Dellapenta
15. Birthplace: Italy

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-29-47 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 8/30 (Date rec'd by registrar) 1947 J. Carroll Cunningham Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 19 47 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 19 41 to August 19 19 47 and that I last saw h im alive on August 19 19 47

Immediate cause of death	DURATION
Gangrene of the small bowel	24 hours
Due to: Incarcerated hernia (left direct inguinal)	indefinite
Due to: With strangulation	24 hours
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Maryland Date signed: 8-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47d

Registered No. 6643

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 Linhigh Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Fullerton (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Linhigh Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Doyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Marie Jensen Doyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
59	2		hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business Owner

FATHER
12. Name John J. Doyle
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Quinn
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. John J. Doyle
(b) Address 110 Linhigh Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lasvahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) Aug 23/47 (Date rec'd by registrar) Mrs. G. L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21st 19 47, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 19 47, to 8/21 19 47, and that I last saw h[illegible] alive on 8/20 19 47.

Immediate cause of death CANCER OF THE LUNG — Duration 2 YRS.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W Machen M.D.
Address 633 Belair Rd Date signed 8/21/47 M.D.

VS 150

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. 41 06756

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore ~~City~~, Maryland
(b) Street address Sparrows Pt.-Dundalk Bridge
(c) Hospital or institution: Sparrows Pt., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2029 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE F. DYKES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
46	Jan	30	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Festus Dykes
13. Birthplace Virginia

MOTHER
14. Maiden Name Carrie Lightfoot
15. Birthplace Virginia

16 (a) Informant Carrie H. Dykes
(b) Address 2029 Madison Avenue

17 (a) Removal (b) Date thereof 9-5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Culpper
Location Virginia

18 (a) Funeral director Archibald A. Gaddis
(b) Address 2101 McCulloh St.
Baltimore, Md.

19 (a) 9/11/47 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 19 47, at 9:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found: 8-31-47 at 9:30 P. M.(?)
(b) Where did injury occur? Found: Sparrows Pt.-Dundalk Br.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature for: George G. Merrill, M.D. M.D.
Date signed 9/2/47

VS 151

VS A15 9-45-15M

Dr. White

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13b

06757

Reg. Dist. No. 38

8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Parkville
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 2915 Putty Hill Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Parkville
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 2915 Putty Hill Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ANNA T. ELTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Robert W. Elton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1877

8. AGE: Years	Months	Days	If less than one day
69	9	22	..... hrs. ..... min.

9. Birthplace: Boston, Mass (Town, county, and state)
10. Usual occupation: at home
11. Industry or business

FATHER
12. Name: Dennis Ronan
13. Birthplace: Ireland

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Mr. Robert W. Elton
Address: 2915 Putty Hill Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/12/47 (month) (day) (year)
Cemetery or crematory: Moreland Mem. Pk.
Location: Baltimore, Md.
18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Road, 14

19. 8/11 1947 (Date recd by registrar) Jas. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 9th, 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4, 1947, to Aug 8 1947 and that I last saw h er alive on Aug 8. 1947.

Immediate cause of death	DURATION
Pulmonary Tuberculosis, Bilateral,	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: James E. White M. D. or other
Address: 5214 Harford Rd Date signed: 9 Aug 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161a

06758

CERTIFICATE OF DEATH

Reg. Diat. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Jones Creek Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7301 Bayfront Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Dewey A. Ferrell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 22, 1909

8. AGE: Years | Months | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Robert Ferrell
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Esther Kinsler
15. Birthplace: W. Va.

18. Informant: Robert Ferrell
Address: 7301 Bayfront Rd. Sparrows Point Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 26, 1947 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave.

18. Fuoeral director: Roland L. Fisher
Address: 2112 Dundalk Ave.

19. 8/26/47 19.. (Date rec'd by registrar) Registror

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 24 19 47, at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.., to ..... 19..
and that I last saw h... alive on ..... 19..

Immediate cause of death	DURATION
Post Partum Atelectasis	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: N. Brewer M.D. M. D. or other
Address ..... Date signed 8/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 b

06759

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Baltimore

City or town Notch Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Religious Grad

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Notch cliff (rural) near Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sister Mary Almeda Fichter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1891

8. AGE: Years	Months	Days	If less than one day
56		9	hrs. min.

9. Birthplace Pittsburgh Pa.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER 12. Name Philip Fichter

FATHER 13. Birthplace Pittsburgh Pa

MOTHER 14. Maiden name Josephine Link

MOTHER 15. Birthplace Pittsburgh, Pa.

16. Informant Sr. Mary Clara

Address Notch Cliff, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 27/47 (month) (day) (year)

Cemetery or crematory Notch Cliff

Location Glen Arm

18. Funeral director Geo M Smith & Son

Address 811 N. Eutaw St.

19. 8/27 19.47 (Date rec'd by registrar) Hallie M Kammer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 19.47, at 8.00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947, to Aug 24 1947 and that I last saw h.er alive on Aug 20 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	26 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Neil Kreeger M. D. or other

Address Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06760

46b

Reg. Diat. No. 43

1. PLACE OF DEATH:

County: Baltimore

City or town: Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Fitch Ave. #495

(If rurol, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth K. Fitch

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: George W. Fitch

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 15th, 1872

8. AGE: Years	Months	Days	If less than one day
75	4	26	..... hrs. ..... min.

9. Birthplace: Washington D.C.

(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: John Hoerner

13. Birthplace: Germany

MOTHER — 14. Maiden name: Rosie Gross

15. Birthplace: Germany

16. Informant: Mr. George W. Fitch

Address: Fitch Ave., Raspeburg

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/13/47 (month) (day) (year)

Cemetery or crematory: St. Johns Lutheran

Location: Parkville, Md.

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road

19. Aug. 11 1947 (Date rec'd by registrar) Mrs. A.L. Reifsnider Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: August 11th 1947, at 6:30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 29 1946 to Aug 5 1947 and that I last saw h-- alive on Aug 5 1947

	DURATION
Immediate cause of death: Carcinomatosis	6 mos
Due to: Gastric Carcinoma	6 mos
Due to:	
Other conditions: Hypertensive cardio-vascular disease (Include pregnancy within 3 months of death)	10 yrs

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. K. Geller M. D. or other

Address: Gudge Rd - Balto - 6 md - Date signed Aug 11/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

63c

06764

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wic.

City or town: Quantico
(If outside city or town limits, write RURAL and give nearest town)

Street No.: None
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: FRENCH, Roy A.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3-10-94

8. AGE:

Years	Months	Days	If less than one day
53	5	10	..... hrs. ..... min.

9. Birthplace: South Dakota
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: James A. French
13. Birthplace: Maine

MOTHER
14. Maiden name: Ada Maxwell
15. Birthplace: Albany, New York

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory: Private Cemetery

Location .....

18. Funeral director: Lilly & Zeiler
Address: Wolfe St., Balto., Md.

19. Aug 21 19 47 (Date rec'd by registrar) A. W. Helwig Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20, 1947, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12, 1947, to August 20, 1947 and that I last saw him alive on August 20, 1947

Immediate cause of death	DURATION
Myocardial Insufficiency	Unknown
Due to: Coronary arteriosclerosis	Unknown
Due to:	
Other conditions: Anasarca, Myxedema and Atrophy of thyroid	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullerson
R. M. CULLISON, M.D. CLIN. Dir. M. D. or other

Address: V.A.H., FORT HOWARD, MD. Date signed: 8-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06762 B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

Opts Home

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balts.

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6906 Bellona Ave

(If rural, give LOCATION)

2.(a) If veteran, name war ..... W

3. (a) FULL NAME Wesley French

3. (b) Social Security Number none

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widower

6.(b) Name of husband or wife: Lulu

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 17. 1859

8. AGE: Years 87 | Months 10 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Retired

11. Industry or business .....

FATHER 12. Name William Matthews

13. Birthplace Baltimore Md

MOTHER 14. Maiden name Rebecca Liddell

15. Birthplace Md

16. Informant Lulu Denoon

Address 6906 Bellona Ave

Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/47 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Catonsville Md

18. Funeral director William Lee Inc

Address 1210 E Cold St

19. 8-14 1947 (Date rec'd by registrar) C. W. Wehrly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1947, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Aug 12 1947

and that I last saw h ..... alive on Aug 11 1947

Immediate cause of death Coronary Thrombosis — DURATION 10 days

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Theodore Schwarz M. D. or other

Address Baltimore Md. Date signed 8/13

06763

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto

City or town: Boring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Glyndon

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Albert Fuss

3.(b) Social Security Number: 217-20-8854

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mollie Fuss

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 26, 1885

8. AGE: Years	Months	Days	If less than one day
62	3		..... hrs. ..... min.

9. Birthplace: Carroll Co.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Albert W. Fuss
13. Birthplace: Frederick Co.

MOTHER
14. Maiden name: Margaret Woods
15. Birthplace: Carroll Co.

16. Informant: Mary E. Fuss

Address: Glyndon, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 29 1947 (month) (day) (year)

Cemetery or crematory: Pleasant Grove

Location: Carroll Co.

18. Funeral director: J. F. Eline & Sons

Address: Reisterstown, Md.

19. Aug - 29 - 1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1947, at 7 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-26-'47 1947, to 8-26-'47 1947

and that I last saw him alive on not seen alive 1947

Immediate cause of death	DURATION
Coronary Occlusion	10 mins.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dr. D. D. Eagles Med. Exam. M. D. or other

Address: Reisterstown, Md. Date signed: 8-27-'47

06764

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

62

CERTIFICATE OF DEATH

Reg. Dist. No. ____

1. PLACE OF DEATH:
County: Baltimore
City or town: Bradshaw, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto.
City or town: Bradshaw, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Raphael Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Edith Alvina Gabel (EDITH ALVINA GABEL)

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife: William H. Gabel
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1877

8. AGE: Years	Months	Days	If less than one day
69	8	7	____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Henry Herpich
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Jane Mencken
15. Birthplace: Baltimore, Md.

16. Informant: William Irvin Gabel
Address: Raphael Rd., Bradshaw, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/2/47 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18. Funeral director: HENRY SANDER & SONS, INC.
Address: NORTH AVE. & BROADWAY

19. Sept. 2 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 30 1947 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14 1947, to Aug 30 1947
and that I last saw h[illegible] alive on Aug 30 1947

	DURATION
Immediate cause of death: Coronary disease	2 yrs
Due to:	
Due to:	
Other conditions: Arteriosclerosis	10 yrs?

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. none
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Jas O Hodson MD (M. D. or other)
Address: Edgewood, Md. Date signed 8-30-47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164c

CERTIFICATE OF DEATH

66765

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Balto.
City or town Parkville S.O.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
8626 Oakleigh Rd.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Parkville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 8626 Oakleigh Rd.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lee Frock Gemmill (GEMMILL) **3. (b) Social Security Number**

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Margaret C. Gemmill
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4th, 1920

8. AGE:

Years	Months	Days	If less than one day
27	3	21	hrs. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual occupation Operator
11. Industry or business Balto. Transit Co.
FATHER 12. Name Frank R. Gemmill
13. Birthplace Balto. Co., Md.
MOTHER 14. Maiden name Sophia Wimsett
15. Birthplace Balto. Co., Md.
16. Informant Mrs. L. F. Gemmill
Address 8626 Oakleigh Rd., Balto. 14, Md.
17. burial (Burial, cremation, or removal. Which?) Date thereof Aug. 28, 1947 (month) (day) (year)
Cemetery or cremetory Balto. Natal. Cemetery
Location Balto., Md.
18. Funeral director Loudon Funeral Home
Address 7401 Belair Road
19. 8/26 1947 (Date rec'd by registrar) G. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 845 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19 , to 19 , and that I last saw h alive on 19 .

	DURATION
Immediate cause of death Shotgun wounds Chest and throat. Suicide	8/25/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident (Suicide) or homicide Suicide Date of 8/25/47
Where did injury occur? Baysville (City or town) Baltimore (County) Md. (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Rollin C. Hudson M.D. D.M.E. M. D. or other
Address Towson Md Date signed 8/25/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 BC

06766

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. Be correct as is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years, 10 months, 23 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 5 years, 10 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 234 South Gilmor Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Germershausen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 15, 1876

8. AGE: Years	Months	Days	If less than one day
71	-	7	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Boarding house

FATHER

12. Name: Frank Germershausen

13. Birthplace: Germany

MOTHER

14. Maiden name: Mary Weissbede

15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-29-47 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 8/30 (Date rec'd by registrar) 1947 J Carroll Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 1947, at 5:35 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 30 1941, to August 22 1947 and that I last saw h..er alive on August 22 1947

Immediate cause of death	DURATION
Arteriosclerotic heart disease	
with cardiac failure	indefinite
Due to: Hypertensive cardiovascular disease	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. (M. D. or other)

Address: Catonsville-28, Md. Date signed: 8-25-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06767

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

1. PLACE OF DEATH:
County: Balto Co.
City or town: Glenarm
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Glenarm
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Benj. F. Giffin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age yeare

7. Birth date of deceaeed (mo., day, yr.) Feb. 10 - 1883

8. AGE:

Years	Months	Days	If less than one day
64	5	30	hrs. ✓ min.

8. Birthplace: Balto Co Md.
(Town, county, and state)
10. Usual occupation: Merchant.
11. Industry or business:
FATHER 12. Name: Benj F. Giffin
13. Birthplace: Md.
MOTHER 14. Maiden name: Eliza Hale
15. Birthplace: Md.
16. Informant: Bessie Giffin
Address: Glenarm Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 17 1947 (month) (day) (year)
Cemetery or crematory: Trinity Cem
Location: Longcen Md.
18. Funeral director: Chas E Arthur
Address: Fork Md.
19. Aug 11 1947 (Date rec'd by registrar) C. E. Arthur Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 1947, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1947, to Aug 9 1947, and that I last saw h alive on August 7 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 Min
Due to Hypertension	
Due to Cardiovascular Dis	4 yrs
Due to	
Other conditions (Stated) Pyelitis chron	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death wae due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Meene of injury Injured at work?

23. SIGNATURE Clifford F. Herman, M.D.
M. D. or other
Address Fork, Md. Date signed 8/11/47

06768 C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47c

CERTIFICATE OF DEATH

pc

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 75 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 701 S. Montford Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ANDREW J. GORTWEITZ

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 5-17-98

8. AGE: Years	Months	Days	If less than one day
49	3	0	____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Isadore Gortweitz
13. Birthplace: Poland

MOTHER
14. Maiden name: Johanna Wisniewski
15. Birthplace: Poland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/20/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Henry Howard H. Blight Jr. Blight Funeral Home

Address: 4914 Belair Rd., Balto., Md.

19. 8-20 19 47 (Date rec'd by registrar) G A Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17, 19 47, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3, 19 47, to Aug. 17 19 47 and that I last saw him alive on Aug. 17 19 47

Immediate cause of death	DURATION
Bronchogenic carcinoma of lung	8 Mos.
metastatic to vertebrae, rib, pleura, plus.	
Due to liver and meninx (dura)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. M.D. or other

Address: V.A.H. FT. HOWARD, MD. Date signed: 8-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

P6769 P

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Harbor View

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore Co.

City or town Harbor View

(If outside city or town limits, write RURAL and give nearest town)

Street No. 606 S. 46th Street

(If rural, give LOCATION)

2.(a) If veteran, name war ....no....

3.(a) FULL NAME Walter J. Gryglik

3.(b) Social Security Number 217-09-8288

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Lois J Gryglik

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 18 1920

8. AGE: Years	Months	Days	If less than one day
27			..... hrs. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation machanic

11. Industry or business Glen L. Martin

FATHER 12. Name Alexsander Gryglik

13. Birthplace Poland

MOTHER 14. Maiden name Rosalia Galanek

15. Birthplace Poland

16. Informant Mrs Lois Gryglik

Address 606 46th Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-11-47 (month) (day) (year)

Cemetery or crematory Holy Rosary Cem

Location Baltimore County

18. Funeral director John H. Weber

Address 401 S. Chester Street

19. 8/8 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MEDICAL CERTIFICATION

345

20. DATE OF DEATH aug 7 1947, at P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death 1. Malignant Hypertension	
2. Cerebral Hemorrhage	30 m.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Smithwick Operation Smithwick Date of op. June & May 47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE M Bowers M.D.

Address Dept. Med. Examiner Baltimore Md. Date signed 8/8/47

M. D. or other

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122a

06770

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto.
City or town 9E. Elm Ave. Overlea
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Overlea
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 E Elm Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Minnie L. Hanrahan

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband ~~or wife~~ Joseph H.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 14 1872

8. AGE: Years	Months	Days	If less than one day
75	10	21	..... hrs. ..... min.

9. Birthplace Frederick Md.
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name Justus Martin
13. Birthplace Frederick Md.

MOTHER
14. Maiden name Drucilla Howard
15. Birthplace Frederick Md.

16. Informant Leo Hanrahan
Address 11 E ~~Overlea~~ Ave

17. Burial Date thereof Aug 8 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Lorraine Park.
Location Wilson Mill Rd
18. Funeral director Paul W. E. Doggel's Sons
Address 7110 Belair Rd

19. Aug 6 19 47 A. W. Ridout Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 August 19 47 at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from FEBRUARY 19 47, to 5 August 19 47
and that I last saw h... alive on 1 August 19 47

Immediate cause of death	DURATION
Coronary occlusion	Immediate
Due to Coronary sclerosis	2 years or more
Due to Hypertensive Heart Disease	2 years or more
Other conditions Diaphragmatic Hernia	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. .....
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other
Address 2020 N. Charles St. Date signed 5 Aug 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

938

66771

CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural - Shepperd Rd. Monkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Rural - Shepperd Rd Monkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Shepperd Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: George Henry Harris

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Elizabeth Ashby Harris
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): April 12th 1867

8. AGE: Years: 80 | Months: 4 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Monkton, Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: George Henry Harris
13. Birthplace: Baltimore Co. Md.

MOTHER
14. Maiden name: Eliza Cromwell
15. Birthplace: Baltimore Co. Md.

16. Informant: James A. Harris
Address: Monkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 18 47 (month) (day) (year)
Cemetery or crematory: Mt. Joy
Location: Monkton, Md.

18. Funeral director: Howard S. Mankline
Address: White Hall, Md.

19. 8/19 19 47 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15th 19 47 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 August 19 47 to 11 August 19 47 and that I last saw him alive on 11 August 19 47

Immediate cause of death	DURATION
Congestive Heart Failure	2 weeks
Due to: Arteriosclerosis	Unknown
Due to:	
Other conditions: Uremia	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walter T. Kerr M.D. (M. D. or other)
Address: Cockeysville, Md. Date signed: 15 Aug. 1947

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06772

CERTIFICATE OF DEATH

BC Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 509 Charing Cross Road

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: WILLIAM T. HELD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Mabel Held

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): 9-21-07

8. AGE: Years	Months	Days	If less than one day
39	10	20	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Special Salesman

11. Industry or business:

FATHER — 12. Name: John W. Held

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sadie Travers

15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/47 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Baltimore, Md.

18. Funeral director: John O. Mitchell & Sons

Address: 1900 Eutaw Place, Balto. Md.

19. 8/12/47 19..... (Date rec'd by registrar) A. W. Kedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11, 1947, at 9:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9, 1947, to August 11, 1947 and that I last saw him alive on August 11, 1947

Immediate cause of death	DURATION
TUBERCULOSIS, PULMONARY, BILATERAL	4 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison

R. M. CULLISON, M.D. M. D. or other

Address: Fort Howard, Md. Date signed: 8/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486

06773

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County Balto
City or town Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7 Bogue Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Loretto J. Hillsinger

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife Leonard A. Hillsinger
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28 1878

8. AGE: Years 69 | Months 11 | Days 19 | If less than one day ... hrs. ... min.

9. Birthplace Elliott City Howard Co. Md (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Wm Henry Temmick
13. Birthplace Germany

MOTHER
14. Maiden name Catherine Kuhn
15. Birthplace Maryland

16. Informant Mrs Walker Freeport
Address Bogue Ave Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-20-47 (month) (day) (year)
Cemetery or crematory St Johns
Location Howard County
19. Funeral director E C Higinbothom
Address Elliott City

19. 8 20 1947 (Date rec'd by registrar) E.C. Nunnemacher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1947, at 9 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16 1947, to August 17 1947 and that I last saw h... alive on August 15 1947

Immediate cause of death	DURATION
Metastatic Ca	4 Mo.
a Lung	
Due to Ca of Uterus	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer K. Gallagher M.D. M. D. or other
Address Catonsville 28, Md Date signed 8-15-47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

E.H.O.
COPY SENT TO ~~LOCAL~~ REGISTRAR No.____ DATE 8/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06774

94a BC

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, Institution, or street address where death occurred: Owings Mills

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 330 St Paul St

(If rural, give LOCATION)

2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: Albert Walter Hoffman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	D

6.(b) Name of husband or wife: Don't know

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): April 16 1874

8. AGE:

Years	Months	Days	If less than one day
73	4	8	...hrs. ...min.

9. Birthplace: Cleveland Ohio (Town, county, and state)

10. Usual occupation: Retired Clerk

11. Industry or business: -

FATHER — 12. Name: Mayer Hoffman

FATHER — 13. Birthplace: Ohio

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: "

16. Informant: Mrs Virginia Hardgrove

Address: 330 StPaul St Balto Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 26 1947 (month) (day) (year)

Cemetery or crematory: Reisterstown Meth Cem.

Location: Reisterstown Md

18. Funeral director: Wm Berryman & Sons

Address: Reisterstown Md

19. Aug-25- 19 47 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 19 47 at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-24-'47 19... to 8-24-'47 19...

and that I last saw him alive on not seen alive 19...

Immediate cause of death	DURATION
Coronary Occlusion	10 mins
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? NONE (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dr. D. D. Caples Med. Exam. M. D. or other

Address: Reisterstown, Md. Date signed: 8-25-'47

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

66775

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County Balto.

City or town Moubton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Moubton (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Shepherd Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Basil Brown Holmes

3.(b) Social Security Number 216-01-8765

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Agnes (nee Rhodes) Holmes

6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Feb 7, 1901

8. AGE:

Years	Months	Days	If less than one day
46	6	18	..... hrs. ..... min.

9. Birthplace Moubton, Balto Co., Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name Charles C. Holmes

13. Birthplace Moubton, Md.

MOTHER

14. Maiden name Anna Brown

15. Birthplace Anne Arundel Co. Md.

16. Informant Mrs. Basil B. Holmes

Address Moubton, Md.

17. Burial Date thereof 8-21-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. James

Location Moubton, Md.

19. Funeral director J. Scott Brooks

Address Sparks, Md.

19. 8/20 1947 Anna Price

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 1947 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Aug 19 1947

and that I last saw h. alive on Aug. 15 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions Arteriosclerosis Fibrillation	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

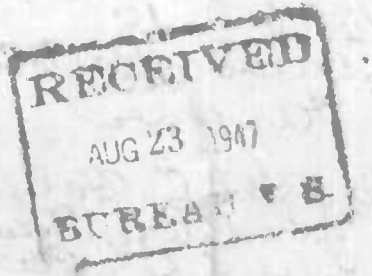
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Frame M. D. or other

Address Parkton, Md Date signed 8/19/47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AUG 23 1947
U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06776

93d

20

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Woods Nursing Home
How long in hospital or institution? 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5501 Edmondson Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Samuel A. Hoover Sr.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	M

6.(b) Name of husband or wife: Katherine Ruth
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 12 - 1868

8. AGE: Years	Months	Days	If less than one day
78	11	11	hrs. min.

9. Birthplace: Balto. City (Town, county, and state)
10. Usual occupation: Retired Hotel Manager
11. Industry or business
FATHER 12. Name: Edgar J. Hoover
13. Birthplace: Balto.
MOTHER 14. Maiden name: Anna M Adams.
15. Birthplace: Balto.
16. Informant: Robert L. Hoover
Address: 428 Crain Hghy - Glen Burnie
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/26/47 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem
Location: Balto
18. Funeral director: Wm Cook Jr
Address: 1217 St Paul St
19. 8/26 19 47 A W Hobert (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 23 - 19 47, at 2 20 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 16 19 47 to Aug 23 19 47
and that I last saw h alive on 19

Immediate cause of death	DURATION
Due to: Cerebral Arterio Sclerosis	2 mon
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L Hoover M. D. or other
Address: Catonsville Date signed 8-25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for the additon of city of death and institution in which death occurred added as per phone conversation with Dr. Howell. 8/25/47 RC

83a

06777

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Opitz, Home (Opitz Home)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2841 Harlem Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Gustavus Henderson Hopkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: Emma Elgert Hopkins
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 2, 1865

8. AGE: Years	Months	Days	If less than one day
82	2	9	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Watchman
11. Industry or business: Retired

FATHER
12. Name: Samuel Hopkins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary E. Hancock
15. Birthplace: Maryland

16. Informant: Gustavus H. Hopkins
Address: 2841 Harlem Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 13, 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md.
18. Funeral director: Frederick A. Cody
Address: 1200 W. Lombard St

19. 8/22/47 (Date rec'd by registrar) J.C. Mommouier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11, 1947, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947 to Aug 11 1947 and that I last saw h... alive on Aug 10 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Catonsville Date signed 8-13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66778

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Turners Sta Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Turners Sta. Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 121 Sollers Pt Rd Dundalk 22
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Alice Parker Howell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Married

6.(b) Name of husband or wife George
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) July 15, 1897

8. AGE: Years	Months	Days	If less than one day
50			..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Walter Stokes
13. Birthplace Md

MOTHER
14. Maiden name Alice White
15. Birthplace Va.

16. Informant George Howell
Address 121 Sollers Point Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 14 47 (month) (day) (year)
Cemetery or crematory Mt Calvary Cem.
Location A A. County Md
18. Funeral director Mrs. Robt. A. Elliott Dept
Address 1124 N. Caroline St.

19. Aug 14 47 (Date rec'd by registrar) 19 ( ) a.m. p.m. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12th 1947, at 1:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11th, 1947, to Aug 12th 1947
and that I last saw her alive on August 12th 1947

Immediate cause of death	DURATION
Cerebral apoplexy	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J H Thomas M.D.
M. D., or other
Address Turners Sta Md Date signed 8/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66779

1700 BC

CERTIFICATE OF DEATH

Reg. Diat. No. 41

1. PLACE OF DEATH

County: Balto.

City or town: Fullerton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Belair Rd & Oakhill Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2025 E. Fayette St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank Hayden Hughes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Evalyn Hughes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 9 1914

8. AGE: Years 33 | Months 3 | Days 20 | If less than one day: hrs. min.

9. Birthplace: W. Va. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business

FATHER — 12. Name: Alvadore Hughes

13. Birthplace: W. Va

MOTHER — 14. Maiden name: Iona Vanscoy

15. Birthplace: unk

16. Informant: Evalyn Hughes

Address: 2025 E. Fayette St

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 31 47 (month) (day) (year)

Cemetery or crematory: Salem Meml

Location: Salem W. Va.

18. Funeral director: Philip Herwig Sons

Address: 2024 Orleans St

19. 8/31 19 47 (Date rec'd by registrar) Marion M. Smulson Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 1947, at 11 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 29 1947, to — 19..

and that I last saw h alive on 19..

Immediate cause of death	DURATION
Crushed chest with	Instant
Due to: Fractured Ribs & Punctured Lungs	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Aug 29 47

Where did injury occur? Fullerton (City or town) Balto. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Public Road

Means of injury: Automobile Injured at work? No.

23. SIGNATURE: Tom Learning M.D.

M.D. or other

Address: Reporty Medical Examiner Date signed: 8-29-47.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of year of birth on page 11 Shannon $112 - 1/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66780

94a

Reg. Dist. No. 43

1. PLACE OF DEATH:

County: Baltimore

City or town: Overlea
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:
3 E. Elm Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Overlea
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3 E. Elm Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Delmar A Hyatt

3.(b) Social Security Number: 174-16-1723

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Angie M. Hyatt

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 13th, ~~1892~~ 1893

8. AGE: Years	Months	Days	If less than one day
54 ~~55~~	7	9	hrs. min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: League Lumber Co.

FATHER
12. Name: Allen Hyatt
13. Birthplace: Pa.

MOTHER
14. Maiden name: Mary Wirsing
15. Birthplace: Iowa

16. Informant: Mrs. D.A. Hyatt
Address: 3 E. Elm Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/25/47 (month) (day) (year)

Cemetery or crematory: Jersey Cemetery

Location: Confluence, Pa.

18. Funeral director: Lasochn Funeral Home.

Address: 7401 Belair Road

19. Aug. 22 1947 (Date rec'd by registrar) Wm. J. T. Richardson Registrar

MEDICAL CERTIFICATION a

20. DATE OF DEATH: August 22nd 1947, at 12:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1946 to August 22 1947 and that I last saw h— alive on Aug 20 th 1947

Immediate cause of death	DURATION
Coronary Occlusion	1 day
Due to: Congenital Arteriosclerosis	2 yrs
Due to: Arteriosclerosis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 1 W. Overlea Date signed: 8/24/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

3 Kinship Rd.

Dr. Davis

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66781

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville 28, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Hood Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville, 28.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Osborne Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: George Louis Jager

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Isabelle Jager

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 31, 1855.

8. AGE: Years: 92 Months: 0 Days: 26 If less than one day: ..... hrs. ..... min.

9. Birthplace: Howard County, Maryland.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER
12. Name: Herman Jager
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Mrs. Cora M. Murphy
Address: 16 Osborne Ave. Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/28/47 (month) (day) (year)

Cemetery or crematory: St. Paul's Lutheran Cemetery

Location: Fulton, Howard Co., Maryland

18. Funeral director: Easton, Sons

Address: 608 Frederick Ave. Catonsville, Md.

19. 8/27/47 (Date rec'd by registrar) H. J. Knowell (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 26 1947, at 9 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1, 1946, to Aug 26 1947

and that I last saw him alive on Aug 26 1947

Immediate cause of death: Uremia Myocarditis

DURATION: 2 mos

Due to: Arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James R. Stonesifer M. D. or other

Address: Catonsville Md. Date signed: 8-27

Evidence for change of birthdate and middle initial of deceased shown on Film G111 8/14/47 dm
Corrected Copy of Death certificate

06783

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 932

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs 11 mo 12 da
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 23 yrs 11 mo 12 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Spring Grove State Hospital
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Gertrude E. W. Iglehart.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	w.	wid.

6.(b) Name of husband or wife: Howard B. Iglehart.
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Apr. 2, 1878 1877

8. AGE: Years	Months	Days	If less than one day
70 - 69	4	11	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Bernard Fallon
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Ella Clarke
15. Birthplace: Baltimore, Md.

16. Informant: Records Spring Grove State Hospital
Address: Catonsville 28, Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 8/15/47 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Baltimore Md.

18. Funeral director: Milburn & Son Inc
Address: 1317 N. Eutaw St.

19. 8-14 1947 A. C. Hedrick M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13 1947, at 5-05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1946 to Aug 13 1947 and that I last saw h.. alive on Aug 13 1947

Immediate cause of death	DURATION
Chronic myocarditis	2+ yrs
Due to	
Due to	
Other conditions Chronic interstitial nephritis. Generalized arteriosclerosis. (Include pregnancy within 3 months of death)	over 2 yrs " 2 "

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Gordon Frank M. D. or other
Address: Spring Grove State Hospital Date signed: Aug 13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136

06782

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 201 days
Hospital, institution, or street address where death occurred:
Vet's. Adm. Hosp. Fort Howard, Md.
How long in hospital or institution? 201 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1206 Sabina Ave. Baltimore 9, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME
JAMES E. IMHOFF

3.(b) Social Security Number
213-03-4306

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 14 1887

8. AGE: Years	Months	Days	If less than one day
60	1	17	hrs. min.

9. Birthplace: Oella, Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: William Imhoff
13. Birthplace: Unknown

MOTHER
14. Maiden name: Susanna Hudson
15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 4-1947 (month) (day) (year)
Cemetery or crematory: Oella
Location: Oella Baltimore Co. Md.

18. Funeral director: Burgee Funeral Home
Address: 3631 Falls Road, Baltimore

19. Sept 3 1947 (Date received by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 1947, at 7:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 11 1947 to August 31 1947 and that I last saw him alive on August 31 1947

Immediate cause of death	DURATION
Tuberculosis pulmonary, chronic, Far advanced	8 months plus
Due to:	
Due to:	
Other conditions: Laryngitis, tuberculous	6 months plus

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
ROBERT M. CULLISON, M.D., Clin. Dir.
M. D. or other
Address: V.A.H. FORT HOWARD, MD. Date signed: 9/1/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V8 AIB 9-45-15M

G6784

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Baltimore - Carney
City or town Harford Rd. North of Joppa Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Carney
(If outside city or town limits, write RURAL and give nearest town)
Street No. Harford Rd North of Joppa Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Amy D. Jenkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Alphonsus L. Jenkins
6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) August 11, 1883

8. AGE: Years	Months	Days	If less than one day
64	15		hrs. min.

9. Birthplace England (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name James Cumma
13. Birthplace ?

MOTHER
14. Maiden name Jane Davies
15. Birthplace England

16. Informant Alphonsus L. Jenkins
Address Harford Rd & Joppa Rd. Carney Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/29/47 (month) (day) (year)
Cemetery or crematory Parkwood Cemetery
Location Taylor Ave

18. Funeral director Howard N. Blight Jr.
Address 6009 Harford Road.

19. Aug 27 1947 (Date rec'd by registrar) C. W. Hedrick MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 19 47, at 9 00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/24/46 19 , to Aug. 26 19 47
and that I last saw h alive on Aug. 26, 1947

Immediate cause of death	DURATION
Metastatic Carcinoma	3 Mo.
Due to Ca of head of pancreas	15 Mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harold A. Pratt M. D. or other
Address 8100 Harford Rd. Date signed 8/27/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C6785

Reg. Dist. No. 83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Glyndon (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Glyndon (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward Johnson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Jennie Johnson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1880

8. AGE: Years	Months	Days	If less than one day
66	9	6	hrs. min.

9. Birthplace: Carroll Co. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Barney Johnson
13. Birthplace: Md.

MOTHER
14. Maiden name: Rachael Williams
15. Birthplace: Carroll Co.

16. Informant: Edward Johnson Jr.
Address: Glyndon Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 17, 1947 (month) (day) (year)
Cemetery or crematory: St. Lukes
Location: Balto. Co.

18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.

19. Aug 16 1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 August 1947, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..., 19..., to 14 August 1947
and that I last saw h.i.m. alive on 14 Aug 47, 19 47

Immediate cause of death	DURATION
Adenocarcinoma of Prostate with metastasis to	? 6 mos
Due to: Bone	
Due to:	
Other conditions: Severe Secondary Anemia	6 mos ?

(Include pregnancy within 3 months of death)

Major findings of operations: Adenocarcinoma Prostate
Date of op. ?
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Ermshar M.D. (M. D. or other)
Address: Reisterstown, Md. Date signed: 15 Aug 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

66786

CERTIFICATE OF DEATH

Reg. Diat. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Lutherville P.O. (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

Broadway Road and Greenspring Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Lutherville P.O. (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Broadway Road and Greenspring Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: ALBERT MERRYMAN JONES

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Myra Belle Jones

6.(c) If alive, give age ////// years

7. Birth date of deceased (mo., day, yr.): March 31, 18 67

8. AGE: Years	Months	Days	If less than one day
80	4	6	..... hrs. ..... min.

9. Birthplace: Shawan, Baltimore Co., Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Caretaker- estate

FATHER

12. Name: Harvey Jones

13. Birthplace: Baltimore Co., Md.

MOTHER

14. Maiden name: Rachel Jones

15. Birthplace: Baltimore Co., Md.

16. Informant: William H. Jones

Address: Lutherville P.O., Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 8, 1947 (month) (day) (year)

Cemetery or crematory: Grace Methodist Cemetery

Location: Falls Road, Lutherville, Balto. Co., Md.

18. Funeral director: John Burns' Sons

Address: Towson, Maryland

19. 8-8-1947 (Date rec'd by registrar) Dr E E Nichols M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6, 1947 19..... at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from For several years 19..... to Aug 6 1947 and that I last saw h.im alive on August 4 1947

Immediate cause of death	DURATION
Carcinoma of tongue	2 years
Due to chronic myocarditis,	—
Due to arteriosclerosis	
Due to	
Other conditions Senility &	—
Senile asthenia	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: E E Nichols M.D. M. D. or other

Address: Pikesville 8- Md. Date signed 8-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66787

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 362 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or Institution? 362 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2110 McCullough Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME

HENRY JONES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Annie Jones

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): 3-23-1894

8. AGE: Years	Months	Days	If less than one day
53	5	3	..... hrs. ..... min.

9. Birthplace: Thumberland City, Va.
(Town, county, and state)

10. Usual occupation: Stevedore

11. Industry or business

FATHER — 12. Name: Madison Jones

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Annie Huddetale

MOTHER — 15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 30 1947 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Baltimore, Md.

Location

18. Funeral director: Geo. H. Holland
Address: 1631 Druid Hill Ave., Balto., Md.

19. Aug. 30 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26, 19 47, at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29, 19 46, to August 26, 19 47 and that I last saw him alive on August 26, 19 47

Immediate cause of death	DURATION
Pulmonary Hemorrhage, due to	1 Yr.
Pulmonary tuberculosis, chr. act.	plus.
Due to: over far advanced	
Due to:	
Other conditions: Diabetes mellitus	1 Yr. plus.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison M. D. or other

Address: V.A.H. FORT HOWARD, MD. Date signed 8-27-47

Aug. Fredrick Registrar

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd V.S.
8/30/77

66788

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 b

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Perry Hall
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Perry Hall
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Belair Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ELIZABETH K. KAHL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Joseph V. Kahl

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 30th, 1880

8. AGE: Years	Months	Days	If less than one day
67	-	1	hrs. min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: Peter Cook
13. Birthplace: Germany

MOTHER — 14. Maiden name: Theresa Butt
15. Birthplace: Germany

16. Informant: Mr. Joseph V. Kahl
Address: Belair Rd., Fullerton

17. burial (Burial, cremation, or removal. Which?) Date thereof 9/2/47 (month) (day) (year)

Cemetery or crematory: St. Joseph

Location: Fullerton, Md.

18. Funeral director: Lassahn Funeral Home.

Address: 7401 Belair Rd.

19. 9/2/47 (Date rec'd by registrar) 19.. Registrar

MEDICAL CERTIFICATION

a

20. DATE OF DEATH: August 31st 19 47 at 1:35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 19 47, to Aug 31 19 47, and that I last saw h.. alive on Aug 31 19 47.

	DURATION
Immediate cause of death: Carcinoma Stomach	2
Due to: Chronic Nephritis & general Arteriosclerosis	2 wks.
Due to: Myocarditis	2 wks.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Michael Rosenfeld M.D.

M. D. or other

Address: 5401 Belair Rd. Date signed 9-2-47

M

I

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

06789

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No. Westchester Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Nellie A. Kavanaugh

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1873.

8. AGE: Years 74 Months 2 Days 0 If less than one day hrs. min.

9. Birthplace Ellicott City Balto. Co. Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Dennis Kavanaugh
13. Birthplace County Mayo, Ireland.

MOTHER
14. Maiden name Elizabeth Martin
15. Birthplace County Mayo, Ireland.

16. Informant Mrs. Lillian Hann
Address Ellicott City, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/2/47 (month) (day) (year)
Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Maryland.

16. Funeral director Easton, Sons
Address Ellicott City, Maryland

19. 9/2/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 August 1947 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 August 1947, to 30 August 1947 and that I last saw h.. alive on 28 August 1947

	DURATION
Immediate cause of death: Uremia	3 wks
Due to: Renal sclerosis	1 year
Due to: Generalized Arteriosclerosis.	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William F. Kavanaugh M.D.
M. D. or other
Address Ellicott City Md Date signed 30 Aug 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66790

22a

CERTIFICATE OF DEATH

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Brooklandville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Brooklandville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Valley Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sister Margaret Jerome Margaret M. Pelletier **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 28 1923

8. AGE: Years: 24 Months: 1 Days: 20 If less than one day: hrs. min.

9. Birthplace: Pleasant Plains Pa (Town, county, and state)

10. Usual occupation: Religious, Teacher

11. Industry or business:

FATHER 12. Name: Jerome Pelletier
13. Birthplace: Pa

MOTHER 14. Maiden name: Margaret Rogers
15. Birthplace: Pa

16. Informant: Sister Rosalia
Address: Rochester Mn

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-20-47 (month) (day) (year)
Cemetery or crematory: Convent Cemetery
Location: Rochester Mn

18. Funeral director: Geo. A. Fuller
Address: Catonsville Md

19. 8/30 19 47 Wilmer & Eisen Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18 1947 at 12 40 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 15 1947, to August 18 47
and that I last saw h.e.r. alive on August 17 1947

Immediate cause of death	DURATION
Heart Failure	72 Hrs.
Due to: Miliary Tuberculosis	9 Months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Charles F. O'Donnell M.D. M. D. or other
Address: 7301 York Rd Date signed: 8/30/47

66791

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: BALTIMORE
City or town: CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 days
Hospital, Institution, or street address where death occurred:
Haarlem Lodge
How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: WASHINGTON
City or town: HAGERSTOWN.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1919 VIRGINIA. AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clarence N. Keller

3.(b) Social Security Number: NONE.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 9, 1886

8. AGE: Years: 60 | Months: Dec. 9 1886 | Days: | If less than one day: hrs. min.

9. Birthplace: Middletown, Maryland (Town, county, and state)

10. Usual occupation: Butcher

11. Industry or business:

FATHER
12. Name: Grant W. Keller
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sadie Meikrick
15. Birthplace: Maryland

16. Informant: Mr. Earl J. Keller
Address: Finksburg, Maryland

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: AUG. 30 1947 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery,
Location: HAGERSTOWN. MD.

18. Funeral director: FRED W. KRAISS
Address: HAGERSTOWN, MD.

19. 8/27/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUGUST 27 19 47, at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUGUST 2 19 47, to AUGUST 27 19 47
and that I last saw h... alive on AUGUST 27 19 47

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	7 days
Due to ARTERIOSCLEROSIS	?
Due to HYPERTENSION	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. V. Williamson M.D.
M. D. or other
Address: 3325 Frederick Ave (29) Date signed: 8/27/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

06792

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

118 Burke Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 118 Burke Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: BERTHA FINK KIEL

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Samuel F.A.Kiel

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): February (?) 18 74

8. AGE: Years	Months	Days	If less than one day
73	5	?	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER — 12. Name: William L. Fink

13. Birthplace: Germany

MOTHER — 14. Maiden name: Louisa Spielman

15. Birthplace: Germany

16. Informant: Samuel F.A.Kiel

Address: 118 Burke Ave., Towson, Maryland

17. Burial, August 7, 1947 (Burial, cremation, or removal. Which?) Date thereof August 7, 1947 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: E. North Ave. & Rose St. Balto., Md.

18. Funeral director: John Burns' Sons

Address: Towson, Maryland

19. Aug. 6, 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4, 1947 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1947 to Aug 4 1947 and that I last saw h.. alive on Aug 4. 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	25 ds.
Due to: Arterio-Sclerosis & Hypertension	Unknown Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. A. Emson M. D. or other

Address: 7201 York Rd Date signed: 8-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Zepp 3400 Windsor Ave
Be At Above Address
8:30 Sharp

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

66793 P.

CERTIFICATE OF DEATH

Reg. Diat. No. 80

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
16 Flushing Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For infants give residence of mother)
State Md County Anne Arundel
City or town Glen Burnie (Gordons)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 600 W. Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harold W W Kissam

3.(b) Social Security Number 214-03-0679

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mildred E
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): July 22. 1884
8. AGE: Years 63 Months - Days 7/8 If less than one day ____ hrs. ____ min.
9. Birthplace: Brooklyn (Town, county, and state) NY
10. Usual occupation: Stuffing Clerk
11. Industry or business: Baltimore Bottling Co
FATHER 12. Name: John N. Kissam Jr
13. Birthplace: Brooklyn NY
MOTHER 14. Maiden name: Elizabeth Mosul
15. Birthplace: Brooklyn NY
16. Informant: Mildred E Kissam
Address: 600 W Drive, Gaylord Md
17. Burial, Cremation, Removal: Cremation Date thereof 8/18/47 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore Md
18. Funeral director: Wilson Cook Inc
Address: 1219 Park
19. 8/15 1947 (Date rec'd by registrar) J.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14th 1947, at 5.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947, to August 14th 1947
and that I last saw h[im] alive on August 13th 1947
Immediate cause of death: Carcinomatosis
August 14th to Aug 14th
DURATION: 3 Days
Due to: Arteriosclerosis. Cerebral Hemorrage Right Side
DURATION: 7 Months 7 days
Due to: Bronchial Pneumonia three times
Last August 8th 1947
Other conditions: Complications of disease
(Include pregnancy within 3 months of death)
Major findings of operations: no operation Urethral on hip in January by Dr George Bennett
Date of op. Jan. 1947
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ns Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Herbert E. Zepp M.D.
M. D. or other
Address: 3400 Windsor Ave Date signed: August 14th 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Underscore correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

G6794

Reg. Dist. No. 43

1. PLACE OF DEATH:

County: Baltimore

City or town: Fullerton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Fullerton
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Simms Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Tekla Krasowsky

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Carl Krasowsky

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 28th, 1882

8. AGE: Years	Months	Days	If less than one day
64	11	11	..... hrs. ..... min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Keralchuk
13. Birthplace: Poland

MOTHER
14. Maiden name: Annie Keralchuk
15. Birthplace: Czernica, Poland

16. Informant: Mrs. Herbert Klein
Address: Simms Ave., Fullerton P.O.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/12/47 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Baltimore

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road

19. Aug 11 1947 A. H. Reginald Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 1947, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19..., to ..., 19...

and that I last saw h... alive on ..., 19...

	DURATION
Immediate cause of death: Heart disease	
Chronic myocarditis, decompensated	2yrs +
Due to: Hypertension	14yr +
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Rollin L. Herbert M.D., D.M.E. M. D. or Other

Address: Towson Md. Date signed 8/9/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF MARYLAND—CERTIFICATE OF DEATH

66795 P.

462

1. PLACE OF DEATH

County Baltimore — Registration Dist. No.

Village or City Stoneleigh — No. 707 Kingston Road St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Viola Margaret Kunkel

(a) Residence: No. 707 Kingston Rd. St., Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Irvin J. Kunkel

6. DATE OF BIRTH (month, day, and year) June 25, 1897

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	50	1	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. House-wife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) York, (State or country) Pa.

FATHER

13. NAME Michael Lauber

14. BIRTHPLACE (city or town) Pa. (State or country)

MOTHER

15. MAIDEN NAME Amanda Rinehart

16. BIRTHPLACE (city or town) Pa. (State or country)

17. INFORMANT Mr. Irvin J. Kunkel

(Address) 707 Kingston Rd.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Rose Cemetery, York, Pa. Date Aug. 16, 1947

19. UNDERTAKER G. Howard Strong

(Address) 3207 W. North Ave.,

20. FILED Aug 17, 1947 — C. C. Hedrick, Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH August (Month) 12 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July, 1937, to 12 August, 1947

I last saw h[er] alive on 12 August, 1947; death is said to have occurred on the date stated above, at 11 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinoma of Ascending Colon	Sept 1946

Other Contributory Causes of importance:

Name of operation Laparotomy Date of July 1946

What test confirmed diagnosis? Pathological Slides Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury ____, 19____

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Charles H. Tain M. D.

(Address) 6201 York Rd. Balto 12 Md.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06796

54b

Reg. Dist. No. 46

1. PLACE OF DEATH:

County: Baltimore

City or town: Middle River.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Middle River

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1436 Stone Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna M Lang.

3.(b) Social Security Number:

4. Sex: F

5. Color or race: W.

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: John H Lang.

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Apr 14 1890

8. AGE: Years: 57 Months: Days: If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business:

FATHER — 12. Name: Charles Steinert

13. Birthplace: Germany

MOTHER — 14. Maiden name: Margaret Broda

15. Birthplace: Baltimore

16. Informant: John Lang

Address: 1436 Stone Drive Middle River

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 21. (month) (day) (year)

Cemetery or crematory: Baltimore Cem

Location: City

18. Funeral director: Ulrich Funeral Home

Address: 200 E Orleans St

19. Aug 19 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 17th 1947 at 4 A.M. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Aug 17 1947

and that I last saw her alive on Aug 17 1947

	DURATION
Immediate cause of death: Cerebral Haemorrhage	Sudden
Due to: Carcinoma of Brain	6 mos
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. M. Baumgardner M. D. or other

Address: Balto 6 Date signed: 8-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66797P

932

Reg. Diat. No.....

1. PLACE OF DEATH:

County Balto.

City or town 2911 Hillcrest Ave.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2911 Hillcrest Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME ALEXANDER S. LARNED

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife None

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1861

8. AGE: Years	Months	Days	If less than one day
85	9	16	.....hrs. .....min.

9. Birthplace Alexander, Va.
(Town, county, and state)

10. Usual occupation Lawyer, Retired

11. Industry or business

FATHER 12. Name Alexander S. Larned

13. Birthplace Balto. Md.

MOTHER 14. Maiden name Maria Wilson

15. Birthplace Balto. Md.

16. Informant Mr. C. H. Steffey

Address 2526 Wycliffe Rd.

17. Burial Date thereof 8/19/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Pk. Cem.

Location Balto. Md.

18. Funeral director WM. J. TICKNER & SONS INC.

Address North & Pa. Aves. Balto. 17, Md.

19. 8/19 19 47, A. W. Heinrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1947 19..... at 3:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 13 19 47, to Aug. 16 19 47 and that I last saw h.. alive on Aug. 16 19 47

Immediate cause of death

1) Bronchopneumonia (Bilateral) — DURATION 4 days

Due to 2) Auricular Fibrillation

3) Passive Congestion of Lungs

Due to 4) Arteriosclerosis Generalized

Other conditions 5) Arteriosclerotic Cardio-vascular disease.

(Include pregnancy within 3 months of death)

6) Bilateral Cataracts.

Major findings of operations.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? .....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE Robert L. Williams MD
M. D. or other

Address 2515 Taylor Ave. Balto. 14, Md. Date signed 8/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66798

Reg. Diat. No. 42

1. PLACE OF DEATH:
County Baltimore
City or town Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3118 Hammonds Ferry Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles P. Lehrer
3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Late Hanora L (McGuire)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 16, 1878

8. AGE: Years	Months	Days	If less than one day
68	9	5	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: John Lehrer
13. Birthplace: Pa.

MOTHER
14. Maiden name: Ellen Ahearn
15. Birthplace: Ireland

16. Informant: Orville G. Faulkner
Address 3118 Hammonds Ferry Rd

17. (Burial, cremation, or removal, Which?) Burial Date thereof (month) Aug (day) 26 (year) 1947
Cemetery or crematory New Cathedral
Location Old Frederick Rd

18. Funeral director: Harry A Wiltze
Address 4101 Edmondson Ave

19. (Date rec'd by registrar) Aug. 25 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1946, to Aug. 21 1947
and that I last saw him alive on August 21 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage	7 days
Due to: Hypertension	2 years
Due to: Nephritis	2 years
Other conditions: Paralysis	7 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John L. Coward M. D. or other
Address 515 Drury Lane (Formerly 210 Read St) Date signed 8/22/47

(2)
(I)
(7)
VS A15 9-45-15
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

John C Pound 515 Drury La =
5400 Edmondson Ave

06799

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

CERTIFICATE OF DEATH

Reg. Diat. No. 35

1. PLACE OF DEATH

County: Balto.

City or town: Parkton (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Parkton (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: York Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3. (a) FULL NAME: Daniel Frederick Leight

3. (b) Social Security Number: 170-18-4743

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Elva (nee Ryan)

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Aug 7, 1880

8. AGE: Years: 67 | Months: | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)

10. Usual occupation: Carpenter & gen. labor

11. Industry or business:

FATHER
12. Name: Charles Leight
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden name: Sarah Taylor
15. Birthplace: Balto. Co. Md.

16. Informant: Mrs. D. F. Leight
Address: Parkton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8 (month) 11 (day) 47 (year)

Cemetery or crematory: Hereford Baptist

Location: Hereford, Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. Aug 14, 1947 (Date rec'd by registrar) Mrs Howard S. Mudkine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 8, 1947, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942, to Aug. 8, 1947, and that I last saw h[illegible] alive on Aug. 5, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. M. France M. D. or other

Address: Parkton, Md. Date signed: 8/9/47

VS A15 9-45.15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66800 P

132

BC

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Approximately 6-1/2 Hrs.

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Md.

How long in hospital or institution? Approximately 6-1/2 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 227 N. Bruce Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: GEORGE W. LEOPOLD

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Widowed.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2-27-95

8. AGE: Years	Months	Days	If less than one day
52	5	9	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Jessie Leopold

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Sally ?

15. Birthplace: Unknown

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/9/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Joseph A. Leidy

Address: 409 W. Mount St., Balto., Md.

19. 8/8 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6, 1947, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6, 3:00 PM 1947, to 8/6/47 9:30PM 1947 and that I last saw him alive on August 6, 1947

Immediate cause of death	DURATION
Tuberculosis, pulmonary, bilateral	Unknown
Due to	
Due to	
Other conditions: Renal Tuberculosis	Unknown
Secondary to Pulmonary tuberculosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. J. McCarmne M.D. (M. D. or Coroner)

Deputy Medical Examiner

Address: Dundalk Md. Date signed: 8/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46b

06801

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County BALTIMORE
City or town 22 Dreher Ave, Pikesville 8 Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, institution, or street address where death occurred: 22 Dreher Ave – Home
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County BALTIMORE
City or town PIKESVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 22 Dreher Ave
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME CHARLES HENRY LINDNER
3. (b) Social Security Number

4. Sex MALE
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Mathilde Jaeger
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) December 18 1875

8. AGE: Years	Months	Days	If less than one day
81	7	27	... hrs. ... min.

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual occupation CARPENTER
11. Industry or business RETIRED
FATHER 12. Name GOTTLEIB LINDNER
13. Birthplace GERMANY
MOTHER 14. Maiden name CATHERINE LOCHNER
15. Birthplace ON BOAT ON ATLANTIC OCEAN
16. Informant Elizabeth KEYES MILLS
Address 22 Dreher Ave, Pikesville 8, Md
17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug 18, 1947 (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location Frederick Rd. Balto Md
18. Funeral director Frank H. Newell
Address Pikesville, Md.
19. 8-16-1947 (Date rec'd by registrar) Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 August 1947, at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 August 1947, to 15 August 1947
and that I last saw him alive on 15 August 1947

Immediate cause of death Congestive Heart Failure — DURATION 4 months

Due to
Due to

Other conditions Carcinoma of the Stomach
(Include pregnancy within 3 months of death)

Major findings of operations None made
Date of op.
Autopsy results None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Millard T. Trabrand Jr. M. D. or other
Address Walker Ave & Reisterstown Rd Pikesville Date signed 15 Aug 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

ATTENDANCE DATES & CAUSE OF DEATH CHANGED BY LETTER FROM DR. D'ANTONIO FILMED 9-4-47
G 111-LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06802

93d

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Essex, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Essex, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 428 Virginia ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st World War

3.(a) FULL NAME: Melvin Douglas Lindsay

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband~~ or wife: Myrtle Francis Lindsay
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1894

8. AGE: Years: 53 Months: 4 Days: If less than one day: hrs. min.

9. Birthplace: Balto. Co. Md. Owings Mills
(Town, county, and state)

10. Usual occupation: Meat Cutter

11. Industry or business: Store

FATHER
12. Name: Melvin F. Lindsay
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden name: Annie Duff
15. Birthplace: Balto. Co. Md.

16. Informant: Mrs. Myrtle F. Lindsay
Address: 428 Virginia ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 18. 1947 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore Md.

18. Funeral director: Fluhrer & Fluhrer

Address: 1476 Light St.

19. 8/15/47 19... (Date rec'd by registrar) Jno. B. Connell G Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/14/47 19... at 2.35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~July 11, 1945~~ February 1, 1946 19... to 8/14/47 19... and that I last saw ~~him~~ her alive on 8/14/47 19...

Immediate cause of death: Coronary occlusion — DURATION

Due to: previous coronary occlusion 2 years ago.

Due to:

Other conditions: due to arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph D'Antonio M.D.
M. D. or other

Address: 8552 Phila. Pa. Date signed: 8/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46P

06863 P.

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 26 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1307 N. Bond Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: CURTIS LOCKLEY

3.(b) Social Security Number: 212-03-1138

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Emma Lockley

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): 8-3-99

8. AGE: Years	Months	Days	If less than one day
48	0	15	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Joseph Lockley

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Hester Davis

15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 23 1947 (month) (day) (year)

Cemetery or crematory: Body shipped to Cologna, Va.

Location:

18. Funeral director: Charles R. Law

Address: 802 Madison Ave., Balto., Md.

19. Aug 19 1947 (Date rec'd by registrar) A. W. Holmes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18, 1947, at 6:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23, 1947, to August 18, 1947 and that I last saw him alive on August 18, 1947

Immediate cause of death	DURATION
PRIMARY CARCINOMA OF LIVER METASTATIC TO LUNGS	4½ mos. plus
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison, M.D. or other

R. M. CULLISON, M.D. CLIN. DIR.

Address: V.A.H., FT. HOWARD, MD. Date signed: 8-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06804

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Loreley Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Loreley, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Howard Brown Farm
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frank Louck

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Same~~ Nov-2-1882

8. AGE:

Years	Months	Days	If less than one day
64	9	5	hrs. min.

9. Birthplace Chesterbrook (Town, county, and state)
10. Usual occupation Caretaker
11. Industry or business

FATHER
12. Name Joseph Louck
13. Birthplace Chesterbrook

MOTHER
14. Maiden name Sarah Jones
15. Birthplace Chesterbrook

16. Informant Anna Mitsch
Address 121 N. Port St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug-11-1947 (month) (day) (year)
Cemetery or crematory Oak Hill
Location Hanover Lane
18. Funeral director Charles Schumacher
Address 2601 E. Madison

19. Aug 8th 1947 (Date rec'd by registrar) John E. Comelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death — DURATION
Coronary Occlusion
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. McCarmine M.D. (M.D. or other)
Address Deputy Medical Exr Date signed 8-7-1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46a

06805

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Baltimore

City or town: Arbutus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 1320 Linden Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1320 Linden Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edgar T. Lawman Sr

3. (b) Social Security Number 216-10-4988

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Katherine Lawman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 24. 1893

8. AGE: Years	Months	Days	If less than one day
54	4		hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Auto Mechanic

11. Industry or business: Mack Truck Co.

FATHER — 12. Name: Nicholas Lawman

13. Birthplace: Md.

MOTHER — 14. Maiden name: Emma Starle

15. Birthplace: Md.

16. Informant: Mrs. Katherine Lawman

Address: 1320 Linden ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 28/47 (month) (day) (year)

Cemetery or crematory: Loudon Pk.

Location: 3801 Frederick Road

18. Funeral director: Harry A. Nitzke

Address: 4101 Edmondson Ave.

19. Aug 26 1947 (Date rec'd by registrar) Geo. Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 24/47. 19 at 10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....

and that I last saw h alive on ..... 19 .....

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to	
Due to Carcinoma of the	
Other conditions Oesophagus	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. T. Kieffer Jr. M. D. or other

Address: 1010 Ludman Date signed: Aug 26 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06806 C.

108

BC

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltomore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1625 Hanover Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William Lulie

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sophie Elizabeth Otter

Deceased 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 11, 1869

8. AGE:	Years	Months	Days	If less than one day
	77	9	13	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER

12. Name: Jacob Lulie

13. Birthplace: Germany

MOTHER

14. Maiden name: Edith (last name unknown)

15. Birthplace: Germany

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 27/1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: C. A. Li

18. Funeral director: A. Howard Evans

Address: 144 S Charles St

19. 8/25 (Date rec'd by registrar) 19 47 S. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1947 19 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30th, 1947 19 to August 24, 1947 and that I last saw him alive on August 24 1947 19

Immediate cause of death	DURATION
Right lower lobar pneumonia; left broncho pneumonia	24 hours
Due to Chronic hypertensive arterio-sclerotic C-V-R disease	Indefinite
With sclerotic coronary diease	"
Other conditions Sclerotic and senile cerebral changes	"

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M. D. M. D. or other

Address: Catonsville, 28, Md. Date signed: 8/24/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

06807

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

BC

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years, 1 month, 12 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 35 years, 1 month, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3729 W. Garrison Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3. (a) FULL NAME: Louisa Mann

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: ~~unk~~ John Mann

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 9, 1860

8. AGE: Years	Months	Days	If less than one day
87 ~~unk~~	6	20	..... hrs. ..... min.

9. Birthplace: Maryland (Balto.)

(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER

12. Name: ~~unk~~ William Wittgrefe

13. Birthplace: Germany

MOTHER

14. Maiden name: ~~unk~~ Wilhelmina ?

15. Birthplace: Germany

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/2/47 (month) (day) (year)

Cemetery or crematory: Baltimore Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 1-1 1947 (Date rec'd by registrar) A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 1947 at 10:40p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1912 to August 29 1947 and that I last saw her alive on August 29 1947

	DURATION
Immediate cause of death: Cerebral accident	11 hours
Due to: Generalized arteriosclerosis	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.

Address: Catonsville 28, Md. M. D. or other

Date signed 8/30/47

06808

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or Institution? 46 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Baltimore - 25
(If outside city or town limits, write RURAL and give nearest town)

Street No. 700 Church Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I V

3. (a) FULL NAME: THOMAS McCORMICK

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7-13-96

8. AGE: Years	Months	Days	If less than one day
51	1	16	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER — 12. Name: John McCormick
13. Birthplace: Ireland

MOTHER — 14. Maiden name: Catherine Dehnan
15. Birthplace: Ireland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 9 2 47 (month) (day) (year)

Cemetery or crematory: BALTIMORE NATIONAL

Location: FREDERICK RD.

18. Funeral director: JOHN F. DENNY, INC.

Address: 715 LIGHT ST. -30

19. 9/2/47 (Date rec'd by registrar) 19..... A. W. Hedrick 98 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 19 47 at 7:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 19 47, to August 29 19 47 and that I last saw him alive on August 29 19 47

Immediate cause of death	DURATION
Pulmonary tuberculosis with cavity formation bilaterally.	2 Mos. plus.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated Above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert Larner M.D. M. D. or other
ROBERT LARNER, M.D.

Address: VAH Fort Howard, Md. Date signed: 8-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

06809

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55d

CERTIFICATE OF DEATH

Reg. Diat. No. 3-

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 11 months, 29 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 3 years, 11 months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Harford County County: Maryland

City or town: Streett
(If outside city or town limits, write RURAL and give nearest town)

Street No.: RFD
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Philip McGibney, Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Emily F. Holloway

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): December 18, 1880

8. AGE:

Years	Months	Days	If less than one day
66	8	10	...hrs. ...min.

9. Birthplace: Shure's Landing, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Paper Mill

FATHER
12. Name: Philip F. McGibney

13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Frances Smith

15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 31 1947 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: Street Md.

18. Funeral director: Robert O. Harbine

Address: Delta Pa

19. 9/1 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 1947, at 4:10p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1943 to August 28 1947 and that I last saw him alive on August 28 1947

	DURATION
Immediate cause of death: Cachexia	1 month
Due to: Carcinoma of the right naris	indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed 8-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66810

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Balto.
City or town Reisterstown, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos.
~~Hospital, Institution~~, or street address where death occurred:
114 Westminster Pike
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Reisterstown, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 114 Westminster Pike
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Joseph Patrick McGonigle

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Margery Virginia McGonigle
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1864

8. AGE: Years	Months	Days	If less than one day
83 ~~83~~	6	1	..... hrs. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual occupation Brush Manufacturer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Ireland

MOTHER
14. Maiden name Francis Ratford
15. Birthplace Ireland

16. Informant Mrs. Louise M. Alvey
Address 114 Westminster Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/18/47 (month) (day) (year)
Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.
18. Funeral director WM. J. TICKNER & SONS INC.
Address North & Pa. Aves. Balto. 17, Md.
19. 8/19/47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 47 at 3:30A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-11-'47 19 to 8-15-'47 19
and that I last saw him alive on 8-11-'47 19

Immediate cause of death	DURATION
Angina Pectoris	2 yrs.
Hemiplegia	4 wks.
Due to Hypertensive Cardovascular Disease	2 yrs.
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations
NONE Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide NONE Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury None. Injured at work?

23. SIGNATURE D. D. Eagles M.D. M. D. or other
Address Reisterstown, Md. Date signed 8-15-'47

M

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66811 f

932

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Baltimore
City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred: 1538 Rolling Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1538 Rolling Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: W.W. # 1

3.(a) FULL NAME: John Thomas Mc Hale

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen Patterson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 17, 1890

8. AGE: Years	Months	Days	If less than one day
57	2	5	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Head Clerk Accounting
11. Industry or business: B & O R.R.

FATHER
12. Name: John Mc Hale
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Mc Hale
15. Birthplace: Ireland

16. Informant: Mrs. Helen P. Mc Hale
Address: 1538 Rolling Rd. Relay

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/25/47 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Frederick Rd.

18. Funeral director: Wm. J. Tickner & Sons
Address: North & Pa. Aves.

19. 8/23 19 47 (Date rec'd by registrar) A.W. Medick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/22/47 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 August 1947 to 21 Aug 1947 and that I last saw him alive on 18 August 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	4 hours
Due to: Arteriosclerotic Heart Disease	Unknown.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Bradley Daugherty M.D. M.D. or other
Address: 1264 Francis Ave Halethorpe Md. Date Signed: 22 Aug 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06812

9da

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Halbrook

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Liberty Rd + Allen Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Halbrook

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Liberty Rd + Allen Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John L. Mengert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: Anna Mary

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	12	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Retired Motorman

11. Industry or business: Balto. Transit Co.

FATHER — 12. Name: Mengert

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs. Thomas Mengert

Address: 43 E. 29th St. New York, N.Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 18/47 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Taylor Ave. - Hamilton

18. Funeral director: Harry H. Nitzke

Address: 4101 Edmondson Ave

8/14/47 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 14/47. 19.... at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12, 1947, to Aug. 14, 1947

and that I last saw him alive on Aug. 14, 1947

Immediate cause of death: Coronary thrombosis — DURATION: 30 min

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown, Md. Date signed: 8/17/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06813 P

183

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Baltimore

City or town: Baltimore C.D. No 4

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore-30

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2407 Kermit Court

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Robert Dale Mershon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 15 1931

8. AGE:

Years	Months	Days	If less than one day
15	9	4?	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: R Dale Mershon

13. Birthplace: Pa

MOTHER

14. Maiden name: Alice Cohen

15. Birthplace: Pa

16. Informant: R Dale Mershon

Address: 2407 Kermit Ct

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/22/47 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Frederick Rd.

18. Funeral director: Edward Fordson

Address: 2359 North Blvd

19. Aug 21 1947 (Date rec'd by registrar) A. M. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1947, at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-19-'47 1947, to 8-19-'47 1947 and that I last saw him alive on not seen alive 1947

	DURATION
Immediate cause of death: Drowning	30 min.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 8-19-'47

Where did injury occur? Lansdowne, (City or town) Balto., (County) Maryland (State)

Injured at home, farm, industry, public place (where?): Cramers Lake

Means of injury: Drowning Injured at work? No

23. SIGNATURE: Dr D. D. Caples, Med. Exam'r M. D. or other

Address: Reisterstown, Md. Date signed: 8-20-'47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06814

Reg. Diat. No. 30

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information if known. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 253 South Robinson St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Andrew Miller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Margaret Chapman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 28, 1898

8. AGE: Years	Months	Days	If less than one day
48	7	12	hrs. min.

9. Birthplace: Baltimore Maryland

(Town, county, and state)

10. Usual occupation: Laundryman

11. Industry or business: Cleaning

FATHER 12. Name: Ambrose Miller

FATHER 13. Birthplace: ~~Unknown~~ Germany

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: "

16. Informant: Hospital Records

Address: Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal—which?) Date thereof Aug. 12-47 (month) (day) (year)

Cemetery or crematory: Sacred Heart

Location: German Hill Rd.

18. Funeral director: John A. Moran

Address: 4201 Chesmont Ave

19. 8/11 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

DM

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9, 1947 19 at 4:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1947 19 to August 9 19 47 and that I last saw him alive on ~~him~~ August 9, 1947 19

Immediate cause of death	DURATION
Subarachnoid hemorrhage	24 hours
Due to: Toxic delirium (alcohol)	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Henry C. A. Mead, M.D.

Henry C. A. Mead, M. D. (M.D. or other)

Address: Catonsville, 28, Md. Date signed: 8/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06815

CERTIFICATE OF DEATH

Reg. Dist. No. 39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Baltimore
City or town: Jarretsville Pike, Jacksonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Jacksonville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Jarretsville
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Elmer Nau

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Belle Nau
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): September 26, 1889

8. AGE: Years: 57 | Months: 10 | Days: 18 | If less than one day: hrs. min.

9. Birthplace: Harford Co. Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: John Franklin Nau
13. Birthplace: Harford Co. Maryland

MOTHER
14. Maiden name: Margaret Catherine Gross
15. Birthplace: Harford Co. Maryland

16. Informant: Mary Belle Nau
Address: Jacksonville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 20, 1947 (month) (day) (year)
Cemetery or crematory: Chestnut Grove
Location: Phoenix
18. Funeral director: J. Scott Boobar
Address: Parkton, Md.

19. 8/20 1947 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1947, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1947, to August 17 1947 and that I last saw h. living alive on August 17 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Walter T. Kees M.D.
M. D. or other
Address: Cockeysville, Md. Date signed: 8-17-47

8

1 15 ~~Basket~~

20 Cake

5 Paper

1 5 Cardfavor

75 Grave

5 Flowers for door

$ 185

185

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

53

06816

CERTIFICATE OF DEATH

Reg. Dist. No. XX

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Trenton Street, ETD
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: JOSEPH C. NIBLETT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Julia E. Niblett
6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): 8/28/93

8. AGE:

Years	Months	Days	If less than one day
54	0	1	..... hrs. ..... min.

9. Birthplace: Salisbury, Maryland (Town, county, and state)

10. Usual occupation: Paper hanger

11. Industry or business

FATHER
12. Name: John Niblett
13. Birthplace: Maryland

MOTHER
14. Maiden name: Johanna Towsend
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/2/47 (month) (day) (year)
Cemetery or crematory: Meadowridge Memorial Cemetery
Location: Baltimore, Maryland

18. Funeral director: Wendell J. Dippel
Address: 312 Highland Avenue, Baltimore, Md.

19. 9/2 19 47 A. D. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 19 47, at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 23 19 47, to August 29 19 47 and that I last saw him alive on August 29 19 47

Immediate cause of death	DURATION
Melanosarcomatosis	8 mos.
Primary site - Skin of the back. 10/22/47-A.S.	
Due to: Unknown	
Due to:	
Other conditions: Tuberculosis, pulmonary, right, active.	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? No

23. SIGNATURE: Robert M. Cullison M.D.
R. M. CULLISON, M.D. CLIN. M.D. or other
Address: V.A.H. FORT HOWARD, MD. Date signed: 8/27/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1952 BC 06817

CERTIFICATE OF DEATH

Reg. Dist. No.

~~COPY~~

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Md.

How long in hospital or institution? 46 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3606 Newland Road
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: NORTH, Samuel M.

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ~~Mary~~ Frances North

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): August 11, 1869

8. AGE: Years	Months	Days	If less than one day
77	11	23	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Retired Educator

11. Industry or business: Mt. Dorcas School

MOTHER FATHER

12. Name: Thomas L. North

13. Birthplace: Baltimore, Maryland

14. Maiden name: ~~Mary~~ Katherine Smith

15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 6, 1947 (month) (day) (year)

Cemetery or crematory: Private Evangelical Reformed

Location: Middletown, Md.

18. Funeral director: William J. Tickner

Address: North & Pennsylvania Aves, Balto., Md.

19. 8-6 1947 (Date rec'd by registrar) a M Hedrick, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3, 1947 at 1:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 1947 to August 3, 1947 and that I last saw him alive on August 3, 1947

Immediate cause of death	DURATION
Aspiration of food	15 Min.
Due to	
Due to	
Other conditions: Dilatation and hypertrophy of heart, slight. (Include pregnancy within 3 months of death)	Unknown

Major findings of operation: Resection of cecum for carcinoma 3 days before death. Date of op.

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison

R.M. CULLISON, M.D. CLIN. Dir. M. D. or other

Address: V.A.H., FORT HOWARD, MD. Date signed: 8-4-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66818

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-47 15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
1229 Vogt Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1229 Vogt Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Irma C. Oelmann

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Kurt Oelmann
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 8, 1908

8. AGE: Years	Months	Days	If less than one day
39	4	7	hrs. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual occupation: H. W.

11. Industry or business

FATHER
12. Name: Frederick C. Rodekurt
13. Birthplace: Md

MOTHER
14. Maiden name: Elsie Horney
15. Birthplace: Md.

16. Informant: Kurt Oelmann
Address: 1229 Vogt Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 18/47 (month) (day) (year)
Cemetery or crematory: Loudon Pk
Location: 3801 Frederick Rd

18. Funeral director: Harry H. Tuttle
Address: 4101 Edmondson ave

19. Aug 8 1947 (Date rec'd by registrar) R. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 15/47. 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 19 47, to Aug 16 19 47
and that I last saw h alive on Aug 16 19 47

Immediate cause of death: Pulmonary Tuberculosis. — DURATION: 6 yrs.
Due to: — DURATION: 8 mos.
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. D. or other
Address: 1127 E St Paul St Date signed: Aug 12, 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66819

50

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
12 Melvin Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12 Melvin Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Augusta Ulmer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 11 1865

8. AGE:

Years	Months	Days	If less than one day
82	6	2	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER — 12. Name: Joseph Ulmer
13. Birthplace: Germany
MOTHER — 14. Maiden name: Regina Troll
15. Birthplace: Germany
16. Informant: George F. Ulmer
Address: 12 Melvin Ave
17. Burial (Burial, Cremation, or removal. Which?) Date thereof 8-16-47 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Baltimore Md
18. Funeral director: Guy C. Talley
Address: Catonsville
19. Aug 15 1947 (Date rec'd by registrar)
J. Carroll Mommonier
Harry W. Fridley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 13 1947 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 2 1947 to Aug 13 1947 and that I last saw h-er alive on Aug 13 1947

Immediate cause of death	DURATION
Chr. Myocarditis	1 Mon
Due to: Arteriosclerosis	
Due to:	
Other conditions: Carcinoma of Breast	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Catonsville Date signed 8-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06820

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH

County: Baltimore

City or town: Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 820 F Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Thomas Passapae

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 2nd 1916

8. AGE: Years: 31 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Second recorder

11. Industry or business: Forty Inch Mill

FATHER

12. Name: Thomas M. Passapae

13. Birthplace: Maryland

MOTHER

14. Maiden name: Nora Fowler

15. Birthplace: Maryland

16. Informant: Mr Thomas M Passapae

Address: 820 F St Sparrows Pt

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/11/47 (month) (day) (year)

Cemetery or crematory: New Balto National

Location: Frederick Ave

18. Funeral director: John F. Kenny Inc

Address: 415 Light Street

19. Aug 16 1947 (Date rec'd by registrar) Dawson L. Farber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7 1947, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 1947, to August 7 1947 and that I last saw h.im..alive on August 5 1947

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Robert E. Farber, M.D.

M. D. or other

Address: Sparrows Point, Md Date signed: 8/7/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06821

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 33

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs
Hospital, Institution, or street address where death occurred:
Berryman's Lane Reisterstown
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Berryman's Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Mrs Maria Pierantozzi

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Nunzio Pierantozzi
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): August 14 1865

8. AGE:	Years	Months	Days	If less than one day
	82	0	11	...hrs. ...min.

9. Birthplace: Offida Italy (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: -

FATHER
12. Name: Domenico Vallorani
13. Birthplace: Italy

MOTHER
14. Maiden name: Rosa Gregori
15. Birthplace: Italy

16. Informant: Mrs Jennie Vagnoni
Address: Berryman's Lane Reisterstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 27 1947 (month) (day) (year)
Cemetery or crematory: All Saints Cemetery
Location: Reisterstown Md
18. Funeral director: Wm Berryman & Sons
Address: Reisterstown Md

19. Aug. 26 1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/25/1947 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/20/1947 to 8/25/1947 and that I last saw h.e.r. alive on 8/24/1947

Immediate cause of death	DURATION
Cerebral oedema	5 days
Due to: arteriosclerosis	
Due to: hypertension	
Other conditions: Exhaustion from extreme heat.	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Jerome L. Sapoff M. D. or other
Address: Reisterstown Md Date signed: 8/25/47

66822 B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52a

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore, County

City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 809 Woodward Street, Balto. 30, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: HENRY W. POEHLITZ

3. (b) Social Security Number: 215-09-4207

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Emma Poehlitz

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 7, 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
57	5	3		

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: FOREMAN

11. Industry or business: MAT. PACK[illegible] Co.

FATHER
12. Name: Carl Poehlitz
13. Birthplace: Germany

MOTHER
14. Maiden name: Mart Rees
15. Birthplace: Baltimore, Maryland

16. Informant: Clinical Records
Address: Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/13/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Frederick Road, Baltimore, Md.

18. Funeral director: George H. Leimbach

Address: 525 N. Lyndhurst St., Balto. 29, Md.

19. 8/11 19[illegible] (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10 19 47, at 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 19 47, to August 10 19 47, and that I last saw him alive on August 10 19 47

Immediate cause of death	DURATION
Carcinoma with Generalized metastesis	Indefinite
Due to: Pathological simple fracture Rt. humerus	
Due to: The original or primary site of the carcinoma was not definitely established. Most likely primary site would be the kidney. (10/1/47 a.s.)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: George H. Smith, M.D.
M. D. or other

Address: V.A. Hospital, Ft. Howard, Md. Date signed: (Aug 14)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

66823

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47e

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Md.
How long in hospital or institution? 61 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Abingdon
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: RAYMOND W. PRICE

3.(b) Social Security Number: 220207209

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Alice Price
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): 4-21-96

8. AGE:

Years	Months	Days	If less than one day
51	3	20	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Policeman

11. Industry or business

FATHER
12. Name: Howard Price
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sadie Swartz
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/13/47 (month) (day) (year)
Cemetery or crematory: Cokesbury Cemetery
Location: Abingdon, Maryland

18. Funeral director: H. K. MCCOMAS & Son.
Address: Abingdon, Maryland

19. Aug. 20 1947 (Date rec'd by registrar) Dawson L. Farber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10, 1947 at 5:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10, 1947, to August 10 1947
and that I last saw him alive on August 10, 1947

Immediate cause of death: Sarcoma, Primary site undetermined with metastases to skull, ribs, and pleura — DURATION: 10 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George W. Smith, M.D. M. D. or other
Address: V.A. Howard VA Hosp. Date signed: (10 Aug 47)

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06824

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 620 North Bend Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 620 North Bend Rd. 29
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ERNEST YEATON PYNE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edna M. Pyne
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Oct. 25, 1890

8. AGE: Years	Months	Days	If less than one day
56	9	28	...hrs. ...min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: Paint Business

FATHER
12. Name: George Pyne
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Abbie Yeaton
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Edna M. Pyne
Address: 620 North Bend Rd., Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/27/47 (month) (day) (year)
Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 8/26 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 23, 1947, at ~~10:50~~ 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to sudden death	
Other conditions Inquiry	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G. M. Tickner Asst. Med Exam Balto Co. M. D. or other
Address: 1010 Leadenhall Date signed Aug. 27, 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

66825

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163

CERTIFICATE OF DEATH

Reg. Diat. No. 42

1. PLACE OF DEATH:

County Balto.

City or town Arbutus, Balto. 28, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Arbutus, Baltimore-28, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4400 Leeds Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Kathryn ~~Katherine~~ G. Reid

3.(b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife Reginald M. Reid

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 9, 1893

8. AGE: Years	Months	Days	If less than one day
54	2	11	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Home

11. Industry or business

MOTHER FATHER

12. Name George H. Gleim

13. Birthplace Balto. Md.

14. Maiden name Gesina R. Gossman

15. Birthplace Bremen, Germany

16. Intermant Mr. Reginald M. Reid, Jr.

Address 4400 Leeds Ave.

17. Burial Date thereof 8/23/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Pk. Cem.

Location Baltimore Md.

18. Funeral director WM. J. TICKNER & SONS INC.

Address North & Pa. Aves. Balto. 17, Md.

19. 8/23 19 47 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 19 47, at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-20-'47 19 ..... to 8-20-'47 19 .....

and that I last saw her alive on not seen alive 19 .....

	DURATION
Immediate cause of death: Carbon Monoxide Poisoning	1 hr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 8-20-'47

Where did injury occur? 4400 Leeds Ave., Arbutus, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home (Bathroom)

Means of injury Carbon Monoxide Poisoning Injured at work? No

23. SIGNATURE D. D. Eagles, M.D. med. exam.
M. D. or other

Address Reisterstown, Maryland Date signed 8-20-'47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

06826

Reg. Dist. No. 43

1. PLACE OF DEATH:

County: Baltimore

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, institution, or street address where death occurred:
4920 Hazelwood Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4920 Hazelwood Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Lucy L Reinhardt

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: August Reinhardt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 15 1881

8. AGE: Years	Months	Days	If less than one day
65	8	12	..... hrs. ..... min.

9. Birthplace: Baltimore City Md
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: John Wolfrum
13. Birthplace: Baltimore Md

MOTHER
14. Maiden name: Annie Essmer
15. Birthplace: Germany

16. Informant: August Reinhardt
Address: 4920 Hazelwood Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 30 1947 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Baltimore Md

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Rd Balto 6 Md

19. Aug 28 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 27 1947 19 ..... at 6 PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 26 1947 to August 27 1947

and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 Day
Due to Cardio-Vascular Hypertensive disease	5 yrs.?
Due to Arteriosclerosis	5 yrs.?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Michael J. Dausch M. D.
M. D. or other

Address: 10 W. Oneida Ave Date signed: 8/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr Benson

66827P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Baltimore County
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
Mercy Villa
How long in hospital or institution? 2 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ********
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1809 Thornbury road
(If rural, give LOCATION)
2.(a) If veteran, name war: .....

3.(a) FULL NAME: NORA HARDEY ROGERS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles Arunah Rogers
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1868

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78	10	20	.....	.....

9. Birthplace: Buckeystown, Frederick Co. Md.
(Town, county, and state)
10. Usual occupation: At home
11. Industry or business: .....

FATHER
12. Name: Dr. Thomas Edwards Hardey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Catherine Weiner
15. Birthplace: Maryland

16. Informant: Miss Ann Rogers
Address: 4 E. 32nd street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/20/47 (month) (day) (year)
Cemetery: St. Joseph's
Location: Carrollton Manor, Frederick Co. Md.

18. Funeral director: Chas. G. Evans & Son, Inc.
Address: 118 N. Mt. Royal Ave.

19. Aug 19 1947 (Date rec'd by registrar) C. W. Ebaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 17 19 47, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-10 19 47, to 8-17 19 47
and that I last saw h.. alive on 8-17- 19 47

Immediate cause of death	DURATION
Diabetes Mellitus	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: P. O. Flynn M. D. or other
Address: 4 E. Chase St. Date signed 8-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9-45-15M

Dr. Philip Flynn
11 E. Chase street

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06828 D

93d

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: a.a. Anne Arundel

City or town: 5225 Kramme Avenue (If outside city or town limits, write RURAL and give nearest town)

Street No.: Baltimore-25. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Savitsky

3.(b) Social Security Number:

4. Sex: FEMALE female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: Stanley Savitsky

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 18-1891

8. AGE: Years: 55 Months: 11 Days: 10 If less than one day: hrs. min.

9. Birthplace: Lithuania (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: John Kluchinsky

13. Birthplace: Lithuania

MOTHER 14. Maiden name: Margaret ?

15. Birthplace: Lithuania

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 1-47 (month) (day) (year)

Cemetery or crematory: St Ludwigs-Frackville, Pa.

Location: Frackville, Pa.

18. Funeral director: F. B. Wippert & Son

Address: 1300 Eutaw Place, Balto-17-47

19. Aug. 28 1947 A.W. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 19 47 at 1:55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18 19 47 to August 27 19 47 and that I last saw her alive on August 27 19 47

Immediate cause of death	DURATION
Acute pylonephritis	indefinite
(organism undetermined)	
Due to: Generalized arteriosclerotic	"
cardiovascular-disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 8-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66829

94a

44

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Baltimore

City or town Edgemere

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town Edgemere

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7101 Old North Ot. Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Genera Scharoun

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Carroll Scharoun

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1900

8. AGE: Years	Months	Days	If less than one day
46			hrs. min.

9. Birthplace Austria (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name unknown

13. Birthplace unknown

MOTHER 14. Maiden name unknown

15. Birthplace unknown

16. Informant Mrs. Carroll Scharoun

Address 7101 Old North Ot. Rd

17. CREMATION (Burial, cremation, or removal. Which?) Date thereof 8 27 47 (month) (day) (year)

Cemetery or crematory GREEN MOUNT

Location GREENMOUNT + NORTH AVE

18. Funeral director JOHN F DENNY, INC.

Address 715 LIGHT ST -30

19. 8-27- 19 47 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23- 1947, at 940 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
a. Coronary Occlusion	5 m
Due to b. Hypertension	
Due to	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M B Davis M.D.

Address Dundalk, Md. Dept. Med. Examiner - Balto. Co. M. D. or other

Date signed 8-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66839

CERTIFICATE OF DEATH

Reg. Dist. No. 9 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 days.

Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore 20
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1114 Cord St.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME HELEN SCHERER

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Arthur L. Scherer, Sr.

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Nov 4, 1904

8. AGE: Years: 42 | Months: 9 | Days: 22 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Pottsville, Pa (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: own Home

FATHER
12. Name: Andrew MacCrady
13. Birthplace: Pottsville, Pa

MOTHER
14. Maiden name: Tillie Bightler
15. Birthplace: Pottsville Pa

16. Informant: Personal History - Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 29-47 (month) (day) (year)

Cemetery or crematory: Ebenezer

Location: Balto Co. Md

18. Funeral director: John E. Connelly

Address: 418 Eastern Ave

19. Aug 27th 1947 (Date rec'd by registrar) John E. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1947 at 3.10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1947 to Aug 26 1947 and that I last saw h[illegible] alive on Aug 26 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	6 Mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: none

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. G. Bridges M. D. or other

Address: Towson 4, Maryland Date signed: 8-26-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

66831

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Rural Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 Del Rey Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Robert Cloud Seip

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Sarah Lee Seip

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 10, 1876

8. AGE:

Years	Months	Days	If less than one day
71	4	25	..... hrs. ..... min.

9. Birthplace: North Dakota
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Robert C. Seip
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Margaret A. McDermott
15. Birthplace: Unknown

18. Informant: Sarah Lee Seip
Address: 11 Del Rey Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-7-47 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Frederick Road

19. Funeral director: Wm. Cook Inc.

Address: 1217 St. Paul St.

19. Aug 6 1947 (Date rec'd by registrar) C. W. Kedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 5 1947, at 1:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1947 to Aug 5 1947 and that I last saw h.l.m. alive on Aug 4 1947

Immediate cause of death	DURATION
Cardiac dilatation + failure	Minutes
Due to: Arteriosclerotic cardiovascular disease & hypertrophy	2 years
Due to: —	
Other conditions: Mitral regurgitation	2 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Stephen Lee Magness M.D.
M. D. or other

Address: 752 Frederick Rd. Date signed: 5 Aug '47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66832

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Belair
(If outside city or town limits, write RURAL and give nearest town)

Street No. 119 Aliceanna Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: FRANK C. SEWELL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Louise Sewell

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): 4-2-88

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
59	4	24		

9. Birthplace: Belair, Md.
(Town, county, and state)

10. Usual occupation: Fork Lifter Operator

11. Industry or business

FATHER
12. Name: John Sewell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rose Sewell
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets.Adm. Hosp.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 31 (1947) (month) (day) (year)

Cemetery or crematory: Belair Md.

Location: Near Belair

18. Funeral director: Edmund E. Bullock

Address: 554 Lewis St. Havre de Grace Md.

19. Aug 27 1947 (Date rec'd by registrar) D. J. Harbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1947 at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 1947 to August 26 1947 and that I last saw him alive on August 26 1947

Immediate cause of death	DURATION
Occlusion of orifice of left coronary artery	Sudden
Due to Aortic Arteriosclerosis and syphilitic changes in the	Unknown
Due to aortic valve [10/10/47 aha]	
Other conditions Chronic passive congestion of viscera	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. M.D. or other
Address: V.A.H. FORT HOWARD, MD. Date signed: 8-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06833

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2822 Elliott Street
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Bertrude Siminski

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Anthony Siminski
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 16 1904

8. AGE:	Years	Months	Days	If less than one day
	43	4	21	hrs. min.

9. Birthplace: Baltimore Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: John Taylor
13. Birthplace: Baltimd

MOTHER
14. Maiden name: Mary Stachowski
15. Birthplace: Baltimd

Personal History- Hospital Records

16. Informant:
Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 9 1947 (month) (day) (year)
Cemetery or crematory: St. Stanislaus
Location: Keightsdtown
18. Funeral director: Marie C. Fralkowski
Address: 1900 E. Kenwood Ave

19. 8/7 47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 6 1947, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1947, to Aug 6 1947
and that I last saw h[illegible] alive on Aug 5 1947

Immediate cause of death	DURATION
Pulmonary TBC	5 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. A. Bridges M. D. or other
Address: Towson 4, Maryland Date signed: Aug 6, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06834

93 e

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Glenarm (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Glenarm (If outside city or town limits, write RURAL and give nearest town)

Street No.: Notchcliff Road (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME VIRGINIA SIMMS

3.(b) Social Security Number

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Thomas E. Simms

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 23rd, 1864

8. AGE: Years 83 Months 1 Days 24 If less than one day ... hrs. ... min.

9. Birthplace: Baltimore County, Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Andrew J. Simms
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden name: Mary J. Bone
15. Birthplace: Baltimore County, Md.

16. Informant: Mr. Thomas E. Simms

Address: Notchcliff Road

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/20/47 (month) (day) (year)

Cemetery or crematory: Waugh Chapel

Location: Baltimore County, Md.

18. Funeral director: Lassahn Funeral Home

Address: 7461 Belair Road

19. 8/18/47 (Date rec'd by registrar) W. M. Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17th 1947 at 6:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1940, to August 17th 1947

and that I last saw her alive on August 17 1947

Immediate cause of death: Heat Exhaustion — Duration: 3 days

Due to: Chronic Myocardial Insufficiency — 14 yrs

Due to:

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Walter M. Hammett M. D. or other

Address: Baldwin Date signed 8/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

66835

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d BE

CERTIFICATE OF DEATH

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Baltimore

City or town: Sparrows Point-14

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 weeks

Hospital, Institution, or street address where death occurred: —

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1113 N. Eutaw St

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Elizabeth Snyder

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife: William Snyder

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 12, 1866

8. AGE:

Years	Months	Days	If less than one day
81	0	4	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER 12. Name: Henry Rehmert

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Elizabeth Bean

MOTHER 15. Birthplace: Germany

16. Informant: Hershey Rehmert

Address: Ave A, Todd's Farm, Sparrows Point Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/20/47 (month) (day) (year)

Cemetery or crematory: St. Paul's

Location: Cardiff Ave

18. Funeral director: Sully & Zeiler Inc

Address: 403 S. Wolfe St

19. Aug 18 1947 E. W. Hedrick Registrar

(Date rec'd by registrar)

85

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1947, at 8 10 F M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 5 1947 to August 16 1947 and that I last saw her alive on August 5 1947

Immediate cause of death	DURATION
Cardiac failure	one day
Due to: Hypertensive cardio-vascular heart disease	widely
Due to:	
Other conditions: Cerebral hemorrhage	3 weeks

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Farber M. D. or other

Address: Sparrows Point, Md. Date signed: 8/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66830

830 DC

Reg. Dist. No. .....

1. PLACE OF DEATH:

County ..... Balto.

City or town ..... Baltimore 16 Fusting Ave.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:
Home In The Pines Nursing Home

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ..... Md. County ..... Baltimore

City or town ..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... 3310 Woodland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war ..... None ✓

3. (a) FULL NAME

LAURA MARIA SODERGREN

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband ~~or wife~~ Emil Harold Sodergren

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1863

8. AGE: Years	Months	Days	If less than one day
83	7	2.	..... hrs. ..... min.

9. Birthplace Faro, Sweden
(Town, county, and state)

10. Usual occupation Home

11. Industry or business

FATHER
12. Name Ludvig Ernst Ringbom
13. Birthplace Sweden

MOTHER
14. Maiden name Anna Katherine Hultgren
15. Birthplace Sweden

16. Informant Mr. Carl J. Sodergren

Address 6002 Highgate Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/6/47 (month) (day) (year)

Cemetery or ~~Crematory~~ Woodlawn Cem.

Location Woodland, Md.

18. Funeral director Wm. J. Tucker & Son

Address North & Penn Aves

19. 8-6 1947 (Date rec'd by registrar) F. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3, 1947 19..... at 9:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27, 1947 to Aug. 3, 1947 and that I last saw her alive on Aug. 2, 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	
with hemiplegia	
Due to Arterio sclerosis	7 days
with hypertension	more
Due to	than 7yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Maurice E. Shamer M.D.
M. D. or other

Address 3300 W. North Ave (16) Date signed 8/4/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66837 8.

186a

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 11 months, 21 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 year, 11 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1804 East Oliver Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William Sommer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 24, 1866

8. AGE:

Years	Months	Days	If less than one day
80	7	15	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Odd jobs

FATHER — 12. Name: Albert Sommer

FATHER — 13. Birthplace: Berlin, Germany

MOTHER — 14. Maiden name: Wilhelmina ? Faber

MOTHER — 15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, ~~cremation or removal~~. Which?) Date thereof 8/11/47 (month) (day) (year)

Cemetery or ~~crematory~~: Trinity

Location: Balto. Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. 8/11 19 47 A W Hebert Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8- 19 47 at 1:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8 19 47 to Aug 8 19 47 and that I last saw him ~~alive~~ dead on Aug 8 19 47

Immediate cause of death	DURATION
Chr. Cardiovascular Disease	2 yrs.
Senile Psychosis	2 yrs.
~~Due to~~ Fractured Left Hip.	6 wks.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None, Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 6/24/47

Where did injury occur? Spring Grove State Hosp. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Catonsville, Md.

Means of injury: Fell out of bed injured at work?

23. SIGNATURE: D. D. Eaples, M. D. Exam. M. D. or other

Address: Reisterstown, Md. Date signed 8-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

06838

30

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
6 Cromarty Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6 Cromarty Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Victoria M. Startt

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Frederick B. Startt

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 17 1872

8. AGE: Years	Months	Days	If less than one day
75	6	28	hrs. min.

9. Birthplace: Rock Hall, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Thomas Crouch

13. Birthplace: Maryland

MOTHER

14. Maiden name: Frances Coleman

15. Birthplace: Maryland

16. Informant: Mrs H. T. Parks (Daughter)

Address: Pentridge Apts.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 18 1947 (month) (day) (year)

Cemetery or Crematory: Chesterfield

Location: Centreville, Md.

18. Funeral director: Wm. J. Tickner & Sons

Address: North & Pennsylvania Aves. 17

19. Aug 18 1947 (Date rec'd by registrar) C. W. Wedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15th 1947 at 3.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 9 1947 to Aug 15 1947 and that I last saw h.. alive on Aug 15 1947

Immediate cause of death	DURATION
Myocardial Insufficiency	2 Days
Due to Arteriosclerosis	
Cardio Vascular Hypertension	few yrs
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. M. Bowman M.D. M. D. or other

Address: 2206 Garrison Blvd. Date signed: 8/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WS A15 9-45-15M

0683 P.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B0 Reg. Dist. No. B0

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 8 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 month, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2123 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Isaac Acie Summerson

3. (b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Estella Stewart

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): June 24, 1889

8. AGE: Years	Months	Days	If less than one day
58	1	19	...hrs. ...min.

9. Birthplace: Pennsylvania - Cross Fork, Potters Co. (Town, county, and state)

10. Usual occupation: cabinet maker

11. Industry or business: own business

FATHER

12. Name: Charles S. Summerson

13. Birthplace: Pennsylvania, Leida, Potters Co.

MOTHER

14. Maiden name: Nancy Miller

15. Birthplace: Pennsylvania, Leida, Potters Co.

16. Informant: Hospital records

Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 15, 1947 (month) (day) (year)

Cemetery or crematory: Moreland Memorial Park

Location: Taylor Av., Balto. Co. Md.

18. Funeral director: Stewart & Mowen Company

Address: 108 W. North Ave., Balto.-1, Md.

19. 8/17 19 47 (Date rec'd by registrar) J. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12 19 47 at 5 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from at death 19..., to August 12 19 47 and that I last saw h... alive on at death 19...

Immediate cause of death	DURATION
Meningitis, (non-purulent	48 hours
Due to: Left upper lobar pneumonia	48 hours
Due to: Chronic arteriosclerotic cardiovascular renal disease.	Indef.
Other conditions: Sclerotic coronary disease with old infarction.	Indef.
Cerebral vascular accident old. (Include pregnancy within 3 months of death)	Indef.

Major findings of operation: subdural hygroma evacuated. Date of op. 7/10/47 (J.H.H.)

Autopsy results: as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Dr D. D. Eagles Med. Exam. M. D. or other

Address: Reisterstown, Md. Date signed: 8-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06840

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Rogers Forge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
526 Dunkirk Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Rogers Forge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 526 Dunkirk Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LONA M. SUMMERSON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Charles A. Summerson
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 30th, 1906

8. AGE: Years	Months	Days	If less than one day
41	2	1	____ hrs. ____ min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Calvin Karnes
13. Birthplace: Va.

MOTHER
14. Maiden name: Dollie Walker
15. Birthplace: W. Va.

16. Informant: Mr. Chas. O. Summerson
Address: 526 Dunkirk Road

17. burial (Burial, cremation, or removal. Which?) Date thereof Aug. 4, 1947 (month) (day) (year)
Cemetery or crematory: Moreland Memorial
Location: Baltimore, Md.
18. Funeral director: Lasahn Funeral Home
Address: 7401 Belair Road
19. Aug 2 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1st, 1947, at 4:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7, 1947, to Aug. 1, 1947
and that I last saw h[illegible] alive on Aug. 1 1947

Immediate cause of death	DURATION
acute Cardiac Dilatation	14 hrs.
Due to Chronic Endocarditis and myocarditis	
Due to (Rheumatic)	20 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: Lloyd E. Saylor M.D.
M. D. or other
Address: 3902 Greenmount Ave. Date signed: 2 aug 1947
Balto - 18 md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06841 P.

94a BC

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH

County Balto.

City or town Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Mota Room 12" Mill

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1428 Eden St.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Aubrey Terry.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col.	Married

6.(b) Name of husband or wife Annie

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1898

8. AGE: Years	Months	Days	If less than one day
48			hrs. min.

9. Birthplace Va. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Abner Terry

13. Birthplace Va.

MOTHER 14. Maiden name Della Fitzgerald

15. Birthplace Va.

16. Informant Annie Terry

Address 1428 N. Eden St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 17/47 (month) (day) (year)

Cemetery or crematory Mt. Calvary Cem.

Location A. A. County Md

18. Funeral director Mrs. P. H. G. Elliott & Dept

Address 1129 N. Caroline St

19. 8-14 1947 A. V. Medick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1947 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. McCarmine M.D. M. D. or Coroner

Deputy Medical Examiner

Address Brooklyn, Md. Date signed 8/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06842

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

121 B

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 183 days

Hospital, institution, or street address where death occurred:

Veterans Hospital, Fort Howard, Md.

How long in hospital or institution? 183 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County:

City or town: Tangier

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: JOHN C. THOMAS

3.(b) Social Security Number: 229-16-0152

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Elvira Thomas

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): October 27, 1901

8. AGE: Years	Months	Days	If less than one day
45	9	17	....hrs. ....min.

9. Birthplace: Tangier, Va.
(Town, county, and state)

10. Usual occupation: Deisel Engineer

11. Industry or business:

FATHER — 12. Name: John Thomas; 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Emma Crochet; 15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/17/47 (month) (day) (year)

Cemetery or crematory: Parks Cemetery
Location: Tangier, Virginia

18. Funeral director: Howard H. Hubbard
Address: 306 Main St. Crisfield

19. 8/14 19 47 (Date rec'd by registrar) A. W. Heddel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14, 1947, at 3:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12, 1947, to August 14, 1947 and that I last saw him alive on August 14, 1947

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic, far advanced	6 Mos. plus
Due to	
Due to	
Other conditions: Bronchiectasis	20 Yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison M.D. or other
R. M. CULLISON, M.D. CLIN. DIR.

Address: V.A.H. FT. HOWARD, MD. Date signed: 8-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d P/C

06843 P

Reg. Diat. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 month 14 Days

Hospital, Institution, or street address where death occurred:

Hoorlem Lodge

How long in hospital or institution? 10 Months 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore City

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Upland Rd

(If rural, give LOCATION)

2.(a) If veteran, name war NO

3. (a) FULL NAME Ida Loving Turner

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 28 1856

8. AGE: Years	Months	Days	If less than one day
91	4Mos	23	..... hrs. ..... min.

9. Birthplace Mississippi (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Christopher B Loving

13. Birthplace Mississippi

MOTHER 14. Maiden name Mary Davis

15. Birthplace Mississippi

16. Informant JK Gundry

Address Hoorlem Lodge, Catonsville, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 8/22/47 (month) (day) (year)

Cemetery or crematory Green Mount

Location Baltimore Md

18. Funeral director Tallman & Son

Address 1245 Light St

19. 8/22 1947 (Date rec'd by registrar) A. M. Hahn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1947, at 11.01 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 1946, to August 20 1947

and that I last saw h alive on August 20 1947

Immediate cause of death	DURATION
Arteriosclerotic Cardio-Vascular Disease	10 YRS+
Due to	
Due to	
Other conditions Sen. City	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE T. C. Cunningham M. D. or other

Address 3629 Edmondson -25 Date signed 8/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

06844

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Balto
City or town: Halethorpe Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 3216 Rosalie Rd.
How long in hospital or institution? 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Halethorpe Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3216 Rosalie Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st World War

3.(a) FULL NAME: HARRY VANDAL

3.(b) Social Security Number: 213-03-1162

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Margaret G. Vandal
6.(c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.): Sept. 30, 1880

8. AGE: Years	Months	Days	If less than one day
66	10	29	...hrs. ...min.

9. Birthplace: Riverside, R. I. (Town, county, and state)
10. Usual occupation: Retired C. P. O.
11. Industry or business: U. S. Navy

FATHER
12. Name: Louis Vandal
13. Birthplace: Canada

MOTHER
14. Maiden name: Margaret -
15. Birthplace: Canada

16. Informant: Mrs. Margaret G. Vandal
Address: 3216 Rosalie Rd., Halethorpe

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/2/47 (month) (day) (year)
Cemetery or crematory: Baltimore National Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. Sept 2 1947 (Date received by registrar) Geo. M. Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29, 1947, at 2:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death: Coronary occlusion — DURATION: 5
Due to:
Due to: Cardio Vascular renal disease
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. M. Kieffer Asst Med Exam Balto
M. D. or other
Address: 1010 Lenhard Date signed: Sept 1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Case Picked Up by S W Williamson

Mail permit to SE Office

5/L 11th St SE.

06845 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 108

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville 28, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 27 das.

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 1 mo. 27 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. 422 57th Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Rena E. Vernon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	married

6.(b) Name of husband or wife: Robert G. Vernon

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): December 5, 1889

8. AGE: Years	Months	Days	If less than one day
57	7	27	...hrs. ...min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Domestic

FATHER
12. Name: George Staub
13. Birthplace: unknown

MOTHER
14. Maiden name: Mary Jane Roach
15. Birthplace: unknown

16. Informant: Hospital Records

Address: Catonsville 28, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug 5-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Md

Location: Near Washington D C

18. Funeral director: W W Chambers Co

Address: Washington D C

19. 8/2 (Date rec'd by registrar) 1947 C.W. Fredrick U.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1, 1947, at 3:00 a M

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from June 5, 1947 to August 1, 1947 and that I last eaw h er alive on August 1, 1947

Immediate cause of death	DURATION
Bilateral lobar pneumonia	20 hrs.
Due to: Generalized cardiovascular disease	indef
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death wae due to external cauees, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Meane of injury ... Injured at work?

23. SIGNATURE: Isadore Tuerk, M. D.
M. D. or other

Address: Catonsville 28, Maryland Date signed 8/1/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66846

53

CERTIFICATE OF DEATH

Reg. Diat. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 519 Hilton Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME FRANK W. VORDEMBERGE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife AMELIA E. VORDEMBERGE 6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) FEB. 1, 1867

8. AGE: Years	Months	Days	If less than one day
80	7		hrs. min.

9. Birthplace Maryland (Town, county and state)

10. Usual occupation Retired

11. Industry or business wholesale drugs

FATHER 12. Name HERMAN VORDEMBERGE

13. Birthplace Germany

MOTHER 14. Maiden name MARGARET E. BODIE

15. Birthplace Germany

16. Informant AMELIA E. VORDEMBERGE

Address 519 Hilton ave Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 11, 1947 (month) (day) (year)

Cemetery or crematory Western cemetery

Location Balto. Md.

18. Funeral director Edward J. MacNabb

Address Catonsville Md.

19. Aug 11 1947 (Date rec'd by registrar) J. Carroll Mommie Registrar

Harry Miller, Dep. T.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9th - 1947, at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 - 1945, to Aug 9 1947

and that I last saw him alive on Aug. 4 - 1947

Immediate cause of death

Carcinoma of Stye on the back wrist — DURATION 3 years

Due to Metastasis to Lung

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. —

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Heming M.D. M. D. or other

Address 203 - Regents Av. Catonsville 28 Md. Date signed 8/10/47.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

66847 P.

CERTIFICATE OF DEATH

BC

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Baltimore 12, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred: Arnold Nursing Home

How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2001 Park Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William E. Walton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8 1851

8. AGE: Years	Months	Days	If less than one day
96	3	23	hrs. min.

9. Birthplace Harford Co. Maryland
(Town, county, and state)

10. Usual occupation Real estate Broker Retired

11. Industry or business

FATHER

12. Name Samuel Walton

13. Birthplace Harford Co. Maryland

MOTHER

14. Maiden name Eliz. Hopkins

15. Birthplace Harford Co. Maryland

16. Informant Dr. Henry T Walton

Address 320 Gettings Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 6/47 (month) (day) (year)

Cemetery or crematory Friend's Cemetery

Location Harford Rd.

18. Funeral director John O. Mitchell & Son

Address 1900 Eutaw Place

19. 8-5 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1947, at 5:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1947, to August 4, 1947 and that I last saw him alive on August 4, 1947

Immediate cause of death	DURATION
Cardio - Respiratory Failure	
Due to Hypertensive Cardio vascular disease	
Due to 10/22/47 G.S.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gustav H. Young M.D. M. D. or other

Address 5411 Tremont Road Date signed 8/4/47

Evidence for change of age 1 year of birth shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66848

FILM No. G 113 NOV 12 1947

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1727 E. Pratt Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3. (a) FULL NAME: JOHN L. WARCZYNSKI

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dorothy Warczynski

6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): ~~8-27-47~~ 12-27-~~47~~ 1916

8. AGE: Years	Months	Days	If less than one day
30 ~~27~~	8	3	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER — 12. Name: Martin Warczynski

13. Birthplace: Germany

MOTHER — 14. Maiden name: Bessie Zarak (M.N. Sasadeusz)

15. Birthplace: Poland

16. Informant: Clinical Records, Vets. Adm. Hosp.,

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2/47 (month) (day) (year)

Cemetery or crematory: St. Stanisclaus Cemetery

Location: Baltimore, Md.

18. Funeral director: Freddy Ozazewski

Address: 1930 Eastern Ave. Baltimore, Md.

19. 9/1 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30, 1947, at 1:05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 27, 1947, to August 30, 1947 and that I last saw h... im... alive on August 30, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Unknown
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Lerner

ROBERT LERNER, M.D. M. D. or other

Address: V.A.H. FORT HOWARD, MD. Date signed: 8/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

66849

38

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 415

1. PLACE OF DEATH:

County: BALTIMORE

City or town: ANNESLIE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 525 OVERBROOK RD.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MD County:

City or town: BALTIMORE

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2621 N. CALVERT ST.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: MARY ADELAIDE WATKINS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

6.(b) Name of husband or wife: CHARLES B.

6.(c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): JULY 6, 1859

8. AGE: Years	Months	Days	If less than one day
88			...hrs. ...min.

9. Birthplace: CHESTERTOWN, MD.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER 12. Name: JAMES BRICE

FATHER 13. Birthplace: CHESTERTOWN, MD.

MOTHER 14. Maiden name: CATHERINE WILMER

MOTHER 15. Birthplace: QUEEN ANNE CO.

18. Informant: MR. WILMER WATKINS

Address: 723 S. CHARLES ST.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 8 28 47 (month) (day) (year)

Cemetery or crematory: DRUID RIDGE

Location: PIKESVILLE

18. Funeral director: JOHN F. DENNY, INC.

Address: 715 LIGHT ST. -30

19. 8/27 (Date rec'd by registrar) 1947 G W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUGUST 26, 1947, at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 27 1947, to Aug 26. 1947 and that I last saw h.. alive on Aug 25. 1947

Immediate cause of death: Cardiac thrombosis — DURATION: 1 wk

Due to: Senile Myocarditis — 4 yrs.

Due to: Arterio Sclerosis — 5 yrs

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. J. Hawthorne M.D. M. D. or other

Address: 1 E. Randall St. Date signed: 8/29/47

Ms. Hawkins

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

B. 66850

Reg. Dist. No.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1801 Homberg ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Frank A. Weber

3. (b) Social Security Number: 217-03-1438

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Separated

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sep 29 1883

8. AGE:

Years	Months	Days	If less than one day
64			____ hrs. ____ min.

9. Birthplace: Manistee Michigan (Town, county, and state)

10. Usual occupation: Bricklayer

11. Industry or business

FATHER
12. Name: Thomas Weber
13. Birthplace: Poland

MOTHER
14. Maiden name: Mary
15. Birthplace: Poland

16. Informant: Frank Weber Jr.
Address: 1801 Homberg ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-20-47 (month) (day) (year)
Cemetery or crematory: Sacred Heart of Mary Cem.
Location: Baltimore County

18. Funeral director: John M. Weber
Address: 401 S. Chester Street

19. Aug 20 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1947, at A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14 1947, to Aug 17 1947
and that I last saw h[illegible] alive on Aug 16 1947

Immediate cause of death	DURATION
(a) Fatal Accident	Aug. 17
Due to, (b) A-S-C-V- Disease	—
Due to, (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: W. Travis Mac. M. D. or other
Address: Hawkins Point - Dundalk Date signed 8-18-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

06851

CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH

County: Balto.

City or town: Phoenix

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Phoenix

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Phoenix Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Hugh James Henry Welch

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Edith Smith Welch

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): June 16, 1908

8. AGE: Years 39 Months 1 Days 20 If less than one day: hrs. min.

9. Birthplace: Kent Co. Delaware (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER — 12. Name: Wilbert L. Welch

FATHER — 13. Birthplace: Greensboro, Md.

MOTHER — 14. Maiden name: Brookes Coll

MOTHER — 15. Birthplace: Kent Island, Md.

16. Informant: Mrs. Edith Welch

Address: Phoenix, Md

17. Burial, 8-9-47 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Jessops Methodist

Location: Sparks

18. Funeral director: Landon M. Brooks

Address: Sparks, Md

19. 8/8/47 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1947 at 11 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from None 19... to ... 19... and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Cerebral hemorrhage.	8/6/47
Due to: Spontaneous internal	
Due to:	
Other conditions: Diabetes mellitus	4 yrs +
Obesity	20 yrs +

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Rollin E. Hudson M.D. D.M.E. M. D. or other

Address: Towson Md Date signed 8/7/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06852

46 BC

Reg. Diat. No.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or Inwn: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 51 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: 1302 Ashbury Road Balto., 7, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: See above.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: WALTER T. WHITTY

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mamie E. Whitty

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): 11-13-1889

8. AGE: Years	Months	Days	If less than one day
57	9	0	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Edgewood Arsnel

11. Industry or business: Government

FATHER
12. Name: Nicholas Whitty
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Corrigan
15. Birthplace: Ireland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/16/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Baltimore, Md.

Location

18. Funeral director: Wm. J. Tickner & Sons Inc.
Address: Baltimore, Md. North & Pa. Ave.

19. 8-14 1947 (Date rec'd by registrar) A. W. Redsmith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13, 1947, at 3:22 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23, 1947 to August 13, 1947 and that I last saw him alive on August 13, 1947

Immediate cause of death	DURATION
Carcinoma of cecum with multiple abdominal metastases	1 Yr. plus
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. M. D. or other
Address: V.A.H. FORT HOWARD, MD. Date signed: 8-13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66853

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Dundalk

City or town Balto

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6814 Holabird Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Dundalk

City or town Balto

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6814 Holabird Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna K. Willis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife Frank E. Willis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 21 - 1883

8. AGE: Years 63 | Months 9 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace Balto - Md.

(Town, county and state)

10. Usual occupation at home

11. Industry or business

FATHER 12. Name John Glossner

13. Birthplace Europe

MOTHER 14. Maiden name Annie C. Ackenberg

15. Birthplace

16. Informant Mrs. Frank E. Willis

Address 6814 Holabird Ave.

17. Burial Date thereof 8/12/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Moreland Park

Location Md.

18. Funeral director Leonard J. Ruck

Address 5305 Harford Rd.

19. 8/11 19 47 C W Hedinger Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 19 47 at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 47 to Aug 8 19 47

and that I last saw h.e.r alive on August 8 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	—
Due to Hypertensive And	
Arteriosclerotic C. Vasc. Dis.	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stephen C. Mackowski M. D. or other

Address 6714 Holabird Ave Date signed 8/8/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

06854
32

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Balto

City or town: Pikesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? July 22, 1941

Hospital, institution, or street address where death occurred: Augsburg Home

How long in hospital or institution? July 22, 1941

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Balto

City or town: Pikesville (8) (If outside city or town limits, write RURAL and give nearest town)

Street No.: Campfield Rd (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Louise S. Wilson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widow

6.(b) Name of husband or wife: Jos. R. Wilson 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 11. 1877

8. AGE: Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: —

11. Industry or business:

FATHER 12. Name: Edw. Eckardt

13. Birthplace: Germany

MOTHER 14. Maiden name: Marg. Reese

15. Birthplace: Germany.

16. Informant: Records

Address: Augsburg Home

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2 47 (month) (day) (year)

Cemetery or crematory: Bally Cem

Location: North Ave

18. Funeral director: L. HECKMANN & SON

Address: 6067 HARFORD Rd.

19. Sept 2 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31. 19 47, at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 5 19 45 to Aug. 31 19 47, and that I last saw h.e.r. alive on Aug. 30th 19 47

Immediate cause of death	DURATION
1) - Cortex - Sclerosis	
Cardio - Vascular Disease	5 yrs.
Due to:	
Due to:	
Other conditions - Diabetes	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results: done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Earl L. Chambers M. D. or other

Address: 4108 Liberty Hts Date signed: 9/2/47

66855

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Balto Co
City or town 2826 Fred Rd Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Month
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto Co
City or town Frederick R
(If outside city or town limits, write RURAL and give nearest town)
Street No. Catonsville Md #28
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William R Wolfe

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widow

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26 1882

8. AGE: Years 65 Months Days If less than one day hrs. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual occupation Farmer.
11. Industry or business Farm
FATHER 12. Name John W Wolfe
13. Birthplace Maryland
MOTHER 14. Maiden name Katherine Grant
15. Birthplace Maryland
16. Informant Mrs Mary E Smith
Address 2826 Frederick Rd.
17. Burial Date thereof 8/14/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory New Cathedral
Location Balto City
18. Funeral director Edw S Mac Nabb
Address Catonsville Md.
19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1947, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1941, to August 12 1947
and that I last saw h alive on August 11 1947

Immediate cause of death: Myocardial Decompensation and Auricular Fibrillation — DURATION 2 mo

Due to: Chr. Hypertensive Cardio-Vascular Disease — 6 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer K. Gallagher M.D.
M. D. or other
Address Catonsville-28, Md Date signed 8-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83c

06856

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above piece of death? 38 Days

Hospitel, institution, or street eddress where death occurred:

Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or Institution? 38 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residenee of mother)

State: Maryland Cuouty: Anne Arundel Co.

City or town: Orchard Beach

(If outside eity or town limits, write RURAL and give nearest town)

Street No.: None

(If rural, give LOCATION)

2.(a) If veleran, name wer

3. (a) FULL NAME: CREIGHTON C. WRIGHT

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of hysband or wife: Bertha Wright

6.(c) If elive, give ege: 63 yeers

7. Birth dete of deceesed (mo., day, yr.): 10-19-78

8. AGE: Yeers	Months	Deys	If less then one day
68	9	25	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, eounty, and state)

10. Usuel occupetion: Unemployed

11. Industry or business

FATHER — 12. Name: Curtis Wright

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lydia Williams

MOTHER — 15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Dete thereof: Aug. 16 47 (month) (day) (year)

Cemetery or cremetory: Meadowridge Memorial Park

Locetion: Washington Blvd.

18. Funeral director: Kreitner Funeral Home

Address: 1216 E. Chaeles St.

19. Aug 15 19 47 (Date rec'd by registrar) A. W. Kedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14, 1947, et 12:45P M

21. I CERTIFY that deeth occurred on the dafe above stated; that I attended deceeeed from July 7, 1947, to August 14, 1947

end thef I last saw h im alive on August 14, 1947

Immediate cause of death	DURATION
ENCEPHALOMALACIA	2 weeks plus
Due to: Cerebral Arteriosclerosis	unknown
Due to:	
Other conditions: Generalized Arteriosclerosis	unknown

(Include pregnaney within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should he charged statistically.

22. VIOLENCE: If death wes due to externel causes, fill in the following:

Accident, suicide, or homicide: Dete of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public piece (where?):

Means of injury: Injured et work?

23. SIGNATURE: P. C. Newnam M.D. M. D. or other

Address: V.A.H. Fort Howard, Md. Dete signed: 8-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06857

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 6 months, 3 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 years, 6 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 830 West Lombard Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Christopher Zippoin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: Nannie Belt Catterton

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 14, 1868

8. AGE: Years	Months	Days	If less than one day
79	2	3	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: Barbering

FATHER
12. Name: John Zipprian
13. Birthplace: Germany

MOTHER
14. Maiden name: Theresa Ansburger
15. Birthplace: Germany

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-26-47 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. 8/28/47 (Date rec'd by registrar) J. Carroll Kunnecke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1947 at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14 1945, to August 17 1947 and that I last saw him alive on August 17 1947

Immediate cause of death	DURATION
Left lower lobar pneumonia	24 hours
Due to Chronic arteriosclerotic cardio-vascular-renal disease	indefinite
Due to With Glomerular nephritis, chronic	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Maryland Date signed: 8-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M